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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 4, Nov 23, 2016 | 2016_250511_0011 | 019456-16, 021976-16, 024225-16, 026676-16 | Complaint |

### Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST SUITE 901 TORONTO ON M3J 2V5

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

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

ROBIN MACKIE (511), HEATHER PRESTON (640), THERESA MCMILLAN (526)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): July 26, 27, 28, 29, August 9, 11, 16, 23, 29, September 9, 13, 15, 19, 20, 21, 22, 27, 28, 29, 30 October 4, 5, 6, 2016.**

**The following complaints were completed along with this complaint inspection, 021976-16 Abuse, 024225-16 Complaints Management 026676-16 Improper Care.**

**Order #901, Inspection Number 2016_250511_0011 was complied on August 4, 2016.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Director of Care (ADOC), Nursing Department Assistant Manager, Resident Assessment Instrument (RAI) Coordinator, Owner/Licensee, Manager and Nurse Consultant (NC) for Assured Care Consulting, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Providers (PCPs), Registered Dietitian (RD), Dietary staff, Resident Support Services Manager, Recreation staff, Food Service Manager (FSM) and family members.**

**During the course of this inspection the Inspectors observed the provision of resident care, reviewed applicable policies, practices, procedures, investigation notes, other evidence and medical records for the identified resident.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Quality Improvement**
**Reporting and Complaints**
**Responsive Behaviours**
**Skin and Wound Care**

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

- **23 WN(s)**
- **12 VPC(s)**
- **8 CO(s)**
- **7 DR(s)**
- **0 WAO(s)**

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 98. | CO #901 | 2016_250511_0011 | 511 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

In 2016, a Critical Incident report (CI) was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) that indicated that the home had received a complaint that alleged poor care and abuse of resident #001. The MOHLTC further received a complaint that alleged resident #001 had been abused. Interviews conducted by MOHLTC Inspectors in July, 2016, identified the following:
a. The Administrator, Director of Care (DOC), President of Assured Care Consulting Inc. (a member of the home's management company), the Nursing Consultant (NC) and the President/Director of Bella Senior Care Residence all confirmed they were aware of an alleged physical abuse of resident #001.
b. The DOC and President of Assured Care Consulting Inc., confirmed that the alleged abuse may have constituted a criminal offence.
c. The Administrator, Director of Care and the President of Assured Care Consulting Inc. confirmed that the police were not notified of the alleged abuse.
d. The home's policy, Investigation Process for Resident Abuse by Formal Caregiver, Volunteer or Visitor, section 4.1 Resident Rights and Safety, subsection 4.1.2, Abuse and Neglect Prevention, revised June 2015, directed the Administrator/Designate to notify the police immediately of any alleged, suspected or witnessed incident that the home suspected may have constituted a criminal offense.
e. The Administrator and DOC confirmed that the police should have been notified of the allegation of abuse of resident #001.

The Administrator, DOC and the President of Assured Care Consulting Inc. confirmed that the policy was not complied with when the licensee failed to notify the police for the alleged, suspected or witnessed incident that the home suspected may have constituted a criminal offense .

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constituted a criminal offence. [s. 98.]

***Additional Required Actions:***

***CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

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

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that 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.

Resident #001's Substitute Decision Maker (SDM) stated they were not notified nor given the opportunity to participate in the plan of care when there was a change in resident #001's condition. A review of resident #001's clinical record indicated the resident had a change in their condition in February 2016. Further review of the clinical record, indicated a family member, that was not the SDM, was notified of the change in condition in February 2016. Interview with the SDM confirmed they had not designated any other person to have participated in the development and implementation of the resident's plan

of care. The SDM stated, during an interview, that they had not been provided an opportunity to discuss the use of treatment modalities related to the resident's change in condition. Interview with RPN #102, confirmed that the SDM had not been provided with an explanation of the treatment that had been implemented for resident #001 when their condition changed. RPN #102 stated the SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care when they had not been provided with an explanation of the resident's change in condition and treatment modalities.

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

A) Continence care:
Review of resident #001's written plan of care, called the kardex, printed in August 2015, and available to staff in a binder at the nurse's station, directed staff to toilet the resident at specific times. According to the kardex, staff were to check the resident during the night. Interview of PSW #123 in September 2016, confirmed they were to check the resident at specific times and change the resident as needed. PSW #123 confirmed that care during the night shift was not always completed as per the plan of care. In October 2016, the DOC confirmed that this was not done on the identified dates and it was the expectation that resident #001 would have had their continence product changed during the night shift.

A review of evidence, showed that on at least six occasions in November and December 2015, there was no continence care provided to resident #001. Resident #001 was not checked nor was their continence product changed during these observations.(640)

B) Peri care:
Resident #001's Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment, completed in October 2015, indicated that the resident had been incontinent. In January 2016, the RAI MDS, indicated the resident's continence condition worsened during the previous 14 day observation period. The written plan of care, available to staff, indicated that resident #001 wore an incontinence product for protection at all times and was at risk for skin breakdown. Staff were directed to provide peri care after each episode of incontinence and to monitor and report any areas of redness, irritation, or open areas.

Review of evidence indicated that peri care had not been provided by staff according to

resident #001's plan of care on at least seven occasions in November and December of 2015.

During interview PSW #116 and the DOC confirmed that resident #001's peri care was not, and should have been, completed with each episode of incontinence according to the plan of care. (526)

C) According to resident #001's RAI MDS assessments completed in October 2015, and January 2016, they required assistance from two staff persons for bed mobility, dressing, personal hygiene and bathing.

A review of evidence indicated that on eight identified days in November and December 2015, PSW staff #112, #104, #128, #112, and #118 had assisted resident #001 with bed mobility, dressing, hygiene and grooming and brief changes with one staff person rather than two persons as directed in the written plan of care.

During Inspector interviews, PSW #104, #112, #118, and #128, confirmed that the plan of care directed two staff to provide care to resident #001. They confirmed that they should not have provided care to the resident with only one staff. They confirmed that when they provided care alone, they had difficulty managing the resident's responsive behaviours and that they had become frustrated and angry with the resident. They confirmed that unsafe bed mobility and positioning techniques were used when dressing, washing, changing the brief and positioning the resident in bed when providing care alone.

When asked why they used one staff instead of two, three of the four PSWs interviewed reported that they were told by the registered staff to get the work done and were short staffed on a regular basis. During interview, the DOC confirmed that staff should not have provided care to resident #001 with only one staff person instead of two as per the plan of care. (526) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A) An allegation from the resident's SDM indicated that resident #001 had not been assessed when the evidence indicated that two PSW's noticed a change in the resident's condition in February 2016.

Review of evidence revealed two PSW's went into resident #001's room on an identified date in February 2016, to provide continence care. The two PSWs provided continence care to resident #001 and were heard to comment on the resident's change in condition. Further evidence indicated the resident was not checked on or assessed until nearly five and one half hours later when checked by the oncoming shift, the change in condition was identifed and an RN arrived approximately five minutes later. The resident was assessed and documented as having a significant change in their condition in the clinical record.

A review of the clinical record had not indicated the resident was reassessed or the plan of care updated when the two PSW's first noted a change in the resident's condition on the identified date. The DOC reviewed the evidence and confirmed the licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when resident #001's care needs changed.

B) A review of the clinical record indicated the resident had an initial decline in their condition in 2016. Interview with RN #101 and RPN #102 indicated the resident's care needs changed significantly and the resident passed away in 2016. A review of the resident's most recent plan of care dated October 2015 did not include the resident's change in condition, goals or interventions when their health condition deteriorated.

Interview with RPN #102 confirmed the Palliative Care Plan was intended to provide guidelines for the interdisciplinary management of the imminently dying resident. RPN #102 confirmed when the physicians order for palliative care was received, the plan of care was to be developed and had not been for resident #001. Interview with RN #101 confirmed the home's plan of care for resident #001, had not been reviewed and revised when the resident’s care needs changed to include palliative care. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #3: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

According to resident #001's RAI MDS assessments in October 2015 and January 2016, they required assistance from two staff for bed mobility and transferring.

A) Transferring:
Review of evidence on 12 identified dates revealed staff used unsafe transferring techniques for resident #001.
On four specified dates in November 2015, six specified dates in December 2015, one specified date in January and one specified date in February 2016, evidence review and staff interview confirmed resident #001was transferred unsafely and at times causing the resident to grimace and appear to be in distress.

B) Turning and Positioning:
Review of evidence on seven identified dates revealed staff used unsafe positioning techniques while roughly turning and positioning resident #001 during care, while the resident was in bed.

During Inspector interview, the DOC confirmed that PSW staff had turned and positioned resident #001 in an unsafe and rough manner and had demonstrated unsafe transferring techniques as noted above. [s. 36.]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 004 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone and were free from neglect by the licensee or staff in the home.

Resident #001's family member provided evidence to the home in April 2016, for an identified time period in 2015 and 2016. According to their health record, the resident had a cognitive impairment and required assistance from two staff for hygiene, grooming, continence and transferring.

A) Emotional Abuse: Review of evidence for an identified time period in 2015 and 2016, indicated that on at least 21 occasions, staff in the home exhibited emotional abuse toward resident #001 through threatening, insulting, intimidating and humiliating gestures, actions, behaviour or remarks, including shunning, ignoring, lack of acknowledgement and infantilization.

1. PSWs #104, #109, #111, #112, #113, #116, #117, #118, #119, #120, #121, #122, #124, #125, #128, #129, and #132 ignored and had not acknowledged the resident while providing care during this identified time. During interview, PSWs #104, #112, #116, #118, #120, #125, and PSW #128 confirmed that, according to the definition of abuse, ignoring and not acknowledging the resident was a form of emotional abuse.

2. PSWs #116 and #117 used profanities in reference to a resident while in their presence as provided in evidence on a identified date in November and December 2015. PSW #104 used a profanity when talking about personal matters to PSW #128, in the presence of a resident as provided in evidence on an identified date in November 2015. During interview, PSWs #104, #116, and #128 stated that these expressions were of an insulting and humiliating nature.

3. During interviews PSWs #118, #128 and #112 stated that during three identified dates they made remarks that were insulting and humiliating to the resident.

4. PSW staff #111, #118, #124, #128 were observed to be mimicking the resident by repeating their verbalizations, as provided in evidence, on identified dates in 2015 and 2016. During interview, the DOC confirmed that staff's mimicking of the resident was humiliating.

5. PSWs #112, #117, #118, #128 exhibited gestures and actions that were threatening, insulting, intimidating or humiliating toward the resident on specified dates in November and December 2015.

On at least 20 occasions, PSWs were observed removing the resident's sheets/covers, quickly and forcefully without speaking to the resident. This resulted in the resident being startled and demonstrating a distressed expression.

During interviews, PSW staff #112, #118, and #128 and the DOC confirmed that these gestures and the forcefulness of the actions were threatening, insulting, intimidating or humiliating to the resident.

6. PSW staff #117, #118, #124 and #128 yelled at the resident with an angry facial expression as reviewed in evidence on several identified dates in 2015 and 2016; PSW staff #118 and #128 confirmed that staff yelling at the resident was an intimidating remark.

7. PSW #118 yelled and made an identified degrading comment to the resident; PSW #118 confirmed that the remark made was degrading to the resident.

8. PSW #124 made gestures and remarks that were insulting and humiliating on two occasions in 2015; The DOC confirmed that these gestures and remarks were insulting and humiliating.

During interview, the DOC confirmed that resident #001 had been emotionally abused by PSW staff when PSWs demonstrated threatening, insulting, intimidating or humiliating gestures, actions or remarks, including ignoring, and lack of acknowledgement of the resident.

B) Physical Abuse: Review of evidence on an identified period in 2015 and 2016, indicated that on at least two occasions, staff in the home exhibited the use of physical force that caused physical injury or pain toward resident #001.

PSW #118 and DOC confirmed that actions taken were physically abusive toward resident #001 as the resident appeared to be in pain.

On an identified date in 2015 PSW #128 physically abused resident #001. The PSW continued to have an angry expression on their face, pushed the resident in their chair, walked away and yelled at the resident. During interview, the PSW stated that they were protecting themselves from the resident's responsive behaviour. They confirmed that the resident was in distress by their observed body movements, and attempts to speak and that this constituted abuse upon resident #001.

During interview, the DOC confirmed that PSW staff #118 and #128 had physically abused resident #001.

3. The evidence demonstrated that on at least seven occasions in November 2015, December 2015 and January 2016, at least five PSWs (#104, #112, #117, #118, and #128) were observed to use excessive force during the resident's care. During interviews PSW staff #104, #112, #118, and #128 stated that they physically held down the resident while providing care. The DOC confirmed that these actions were not appropriate and consisted of the use of excessive force during the resident's care.

C) Neglect: Review of evidence between November 2015, and February 2016, indicated that staff had neglected to provide the resident with the treatment, care, services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of resident #001.

1) Staff did not give resident #001 their privacy in treatment and caring for their personal needs that was needed for the resident's well being.
Review of evidence provided between November 2015 and February 2016, indicated that PSW staff repeatedly failed to provide resident #001 with privacy during treatment and caring for his or her personal needs that was needed for the resident's well being. In particular, evidence for several identified dates in November 2015, December 2015 and January 2016,identified PSW staff #112, #117, #118, #128, and #130 not providing privacy in treatment.

PSW #112 confirmed that the resident appeared cold and frightened. PSW #128 confirmed that the resident should have been partially covered during care to provide them with their privacy. PSW staff #112 and #118 confirmed that the resident had attempted to cover themselves and had a distressed look on their face.

2) Staff failed to use safe transfer and positioning techniques when providing care and treatment to resident #001 as required for the resident's safety and well-being as set out in the resident's plan of care.
Staff neglected to transfer, turn and position resident #001 safely or according to their plan of care. According to resident #001's RAI MDS assessments in October 2015, and January 2016, they required assistance from two staff for bed mobility and transferring. The written plan of care, printed in August 2015, provided direction for care between November 2015 and February 2016 and directed staff to provide extensive assistance from two staff for bed mobility and transferring.

Transferring:
Review of evidence on several identified dates in November 2015, December 2015, January and February 2016, revealed PSWs #104, #109, #113, #116, #118, #124, #125, #128, #130, #132, #136, #137, #139, #140, failed to use safe transfer and positioning techniques when providing care and treatment to resident #001 as required for the resident's safety and well-being and as a result contributed to the resident's distress and risk for injury.

Turning and Positioning:
Review of evidence for identified dates, in November 2015 and December 2015, revealed that PSWs #104, #111, #112, #117, #127, #128, neglected to use safe positioning techniques while turning and positioning resident #001 during care. The resident demonstrated grimacing facial expression and an elevated tone of voice. PSWs #104, #112 and #128 confirmed this.

During interview, the DOC confirmed that PSW staff neglected resident #001 as they turned/positioned them unsafely and had demonstrated unsafe transferring techniques.

3) Staff only provided care by one staff and therefore, failed to provide care by two staff required for the resident's health, safety and well-being as set out in the resident's plan of care.
According to resident #001's RAI MDS assessments completed in October 2015 and January 2016, they required assistance from two staff persons for bed mobility, dressing, personal hygiene and bathing. The written plan of care printed in August 2015, for direction for care between November 2015 and February 2016, indicated that two staff were required when providing care to resident #001 for bed mobility, dressing, hygiene and grooming.

Review of evidence indicated that PSW staff #104, #112, #118, and #128 had assisted resident #001 with bed mobility, dressing, hygiene, grooming and brief changes with one staff person rather than two persons as directed in the written plan of care on several identified dates in November 2015, December 2015 and January 2016.

4) Staff did not implement strategies to manage responsive behaviours required for the resident's health, safety and well-being:
According to their health records, resident #001 had cognitive impairment and responsive behaviours. The resident's written plan of care provided staff with at least 10 strategies to manage the resident's behaviours.

Review of evidence dated between November 2015 and February 2016, revealed that on at least 19 occasions, PSWs #104, #111, #112, #117, #118, #121, #124, #127, #128, and #132 had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours.

During interviews, PSW staff #104, #112, #116, #120, #125, and #128 confirmed that the resident had responsive behaviours. They confirmed they had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours. All PSWs confirmed that the resident appeared to be in distress through facial grimacing and tone of voice with an escalation of behaviours as they provided care while not implementing strategies to manage these behaviours.

During interview, the DOC confirmed that PSW staff had not implemented strategies developed to manage responsive behaviours. They confirmed that the strategies were required by the resident's health safety and well-being and staff not implementing the strategies contributed to the resident's distress and escalation of behaviours during their care.

5) Continence products used were not according to individual assessed needs and therefore, as required for the resident's health, safety and well-being.
Resident #001's RAI MDS assessments completed in October 2015 and January 2016, indicated that the resident was incontinent.

Review of evidence dated November 2015, December 2015 and January 2016, indicated that staff (PSWs #112, #116, #120, #124, #128 and #132) applied continence care products that were not based on the resident's assessed needs, did not properly fit the

resident, and did not promote resident comfort, ease of use, dignity and good skin integrity.

Interview with PSWs #116, #120, #124, and #128, confirmed that staff often used non assessed products to manage resident #001's continence. PSW #112 stated that they thought that it was part of the plan of care, and PSW #116 stated that the resident could demonstrate responsive behaviours during continence care. According to staff interviewed, non-assessed products would diminish the number of brief changes required and was more convenient for staff. Staff stated that the strategies outlined had not promoted resident comfort, ease of use, dignity and good skin integrity. The actions, as identified in the evidence, did not provide the resident with the treatment, care and assistance required for their health, safety and well being.

Interview with the DOC on September 30, 2016, confirmed that staff should have used the assessed continence products for resident #001. The DOC stated they could not verify that the strategies used by PSWs promoted resident comfort, ease of use, dignity and good skin integrity.

6) Staff had not checked for incontinence according to the resident's plan of care and therefore, as required for the resident's health, safety and well-being.
Review of resident #001's written plan of care, called the kardex, printed in August 2015 and available to staff directed staff to toilet the resident at specific times. Interview of PSW #123 on September 30, 2016, confirmed they were to check the resident for incontinence and change the resident as needed. PSW #123 confirmed this was not always done. On October 4, 2016 the DOC confirmed that this was not done on the dates identified and it was the expectation that resident #001 would have had their continence product changed at a minimum as specified in the plan of care.

A review of evidence, indicated that on at least six occasions, there was no continence care provided to resident #001. Resident #001 was not checked nor was their continence product changed on six identified dates for time period of five to ten hours.

7) Staff had not provided peri care according to plan of care and therefore, as required for the resident's health, safety and well-being.
Resident #001's RAI MDS assessments completed in October 2015, and January 2016, indicated that the resident was incontinent. The resident wore an incontinent product and the resident's plan of care indicated that the resident was at risk for altered skin integrity and directed staff to provide peri care with each episode of incontinence.

Review of evidence indicated that peri care had not been provided by PSW staff #104, #111, #116, #117, #119, #120, #123, #124, #127, and #128 according to resident #001's plan of care on at least six occasions on identified dates in November 2015 and December 2015. During interview PSW #116 and the DOC confirmed that resident #001 was at risk for skin breakdown and that peri care should have been completed with each episode of incontinence according to the plan of care.

8) Staff had not turned and positioned resident #001 as clinically indicated and therefore, as required for the resident's health, safety and well-being.
Review of evidence on at least six occasions from November 2015 and December 2015, indicated resident #001 had not received any direct care for several hours during the night shifts. Resident #001 was not turned or repositioned by staff when they were dependent on staff for mobility. MDS assessment identified the resident to be dependent on two staff for mobility as documented in the written plan of care dated October 2015. Interview of PSW #123 confirmed resident #001 required two people for mobility and was not able to move about in bed independently. PSW #123 confirmed resident #001 should have been turned or repositioned and that this was not always carried out. DOC confirmed resident #001's condition was such that it was clinically indicated for this resident to be turned or repositioned as per their assessed care needs. (640)

9) Staff failed to provide resident #001 with adequate fluid consumption and failed to notify the RD regarding the resident's fluid intake, as required for the resident's health, safety and well-being.
Resident #001 was assessed by the Registered Dietitian (RD) and required a specific amount of daily fluid intake as documented in the written plan of care dated October 2015. When the resident had not met their fluid needs for the day, the Registered staff were to assess the resident for signs of dehydration and document results of the assessment in the resident record. If the resident's fluid intake was below their fluid needs for three consecutive days, the resident was to be placed on a fluid watch. The Registered staff were to have activated this task in Point Of Care (POC) to alert the staff to prompt extra fluids. A dietary referral was to be made to notify the (RD) that the fluid watch had commenced. A report run by RPN #102, from POC, indicated that on three consecutive days in 2015, resident #001 was below the assessed fluid needs for each day. There was no referral sent to the RD, no task activated in POC nor any documentation of the assessment for dehydration by a Registered staff. The DOC confirmed there was no referral, assessment or task assigned for resident #001 related to a three day decrease in fluid intake. The DOC confirmed it was the expectation that

this should have been done and the home's Feeding and Hydration policy was not complied with. (640)

10) End of Life Care. Resident not reassessed when staff initially found the resident had a change in their condition as required for the resident's health, safety and well-being. An allegation from the resident's SDM indicated that resident #001 had not been assessed when they had a change in their condition on an identified date in February 2016 when two PSW's were observed to notice a change in the resident's condition.

A review of evidence, for an identified date in February 2016, revealed two PSW's going into resident #001's room. The two PSWs provided continence care to resident #001 and were heard to comment on the resident's health condition. Both PSWs stopped what they were doing, observed and commented on the resident's change in their health condition. The two PSW's then provided an intervention based on the observed resident's condition. The evidence indicated the resident was not observed again by the home's staff until nearly five and one half hours later. There was no documentation of an assessment or evidence of the resident being reassessed or monitored for their change in condition during the identified time period. The evidence further revealed two different PSWs had come into resident #001's room, the following shift, and identified the significant change in the residents condition and had notified a registered staff member. An RN arrived approximately five minutes later and the resident was assessed and documented as having a significant change in their condition.

A review of the clinical record indicated the resident was not reassessed or the plan of care updated when the two PSWs first noted a change in the resident's condition, as required for the resident's health, safety and well-being. Interview with the DOC confirmed the licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when resident #001's care needs changed. (511)

During interview on October 6, 2016, the DOC and Administrator confirmed that the licensee neglected resident #001 when staff failed to provide the treatment, care, services and assistance required for the resident's health, safety and well-being including the following:
1) Failed to fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs;
2) Failed to use safe transferring, lifting and positioning techniques;
3) Failed to follow the plan of care by providing care with one staff person instead of two as directed;

4) Failed to follow the plan of care that directed them in techniques and approaches in the management of resident #001's responsive behaviours;
5) Failed to use continence products according to resident #001's plan of care to promote comfort and dryness;
6) Failed to check the resident's incontinence product according to the resident's plan of care;
7) Failed to provide peri care for each episode of incontinence;
8) Failed to turn and reposition every two hours at night as clinically indicated;
9) Failed to ensure adequate fluid intake or to notify the RD;
10) Failed to provide end of life care according to the plan of care. (526)

D) Failure to protect residents from further abuse, improper care and/or neglect:
According to their health records, resident #001 had cognitive impairment, exhibited responsive behaviours and required assistance with all aspects of their care. The resident's family member notified the home of abuse, improper care and/or neglect of resident #001 and then subsequently provided the home with evidence of alleged abuse between November 2015 and February 2016. According to the home's investigative notes, education files, human resources records, and interviews with staff in the home, the DOC, Administrator, Assured Care Consulting Inc. ("the Manager"), the Nurse Consultant, and the licensee, the licensee failed to protect all residents in the home from abuse, improper care and/or neglect after becoming aware of abuse, improper care and/or neglect upon resident #001.

1. Interviews confirmed that staff in the home became aware of suspected abuse, improper care and/or neglect upon resident #001 as follows:
i) Staff #103 before an identified date in March 2016;
ii) DOC in March 2016 by RN #103;
iii) Administrator in March 2016 by the DOC;
iv) Licensee during the first two weeks of April, 2016 by the DOC and Administrator;
v) Manager of Assured Care Consulting in May 2016 by the complainant;
vi) Nurse Consultant for Assured Care Consulting in May 2016, by the Manager.

2. The DOC confirmed that they investigated allegations of abuse, improper care and/or neglect in April 2016 by reviewing evidence and then stopped the investigation, took no action to protect other residents from abuse, improper care and/or neglect until the investigation started again in late May 2016. All PSWs identified as abusing and /or neglecting or providing improper care to resident #001 continued to provide care to other residents during this time without being re-educated or held accountable for their conduct

described in section A, B and C above and failure to comply with the home's policies for the prevention of abuse and neglect.

3. The DOC and Administrator confirmed that they did not immediately report to the Director, allegations of abuse, improper care and/or neglect, until approximately two months after they became aware of these allegations. The DOC also confirmed that this Critical Incident report had not included all known information according to legislative requirements.

4. The DOC and Administrator confirmed that they failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse, improper care and/or neglect of resident #001 that the licensee suspected may have constituted a criminal offense. The home was issued an immediate Compliance Order on August 4, 2016, to immediately notify the appropriate police force of the alleged abuse, improper care and/or neglect of resident #001, which the licensee suspected may constitute a criminal offense, and complied with this Order on August 4, 2016.

5. A total of 11 PSWs ( #104, #111, #116, #120, #124, #125, #127, #128, #129, #131, #132) in the home were disciplined related to the care and services they provided to resident #001.

6. During interview, the DOC confirmed the 21 PSWs, who had been working on the identified care area, that were identified in the evidence, continued to provide care to residents.

7. The DOC and ADOC confirmed that not all staff had received mandatory training in 2015 up to July, 2016 on the home's "Abuse and Neglect Prevention" policy. Mandatory training on approaches and strategies for residents with responsive behaviours was not provided to all staff in 2015 and for 2016 no staff in the home had received this education as of October 6, 2016. They confirmed that PSW staff had difficulty managing specified responsive behaviours and this may have contributed to their abuse, neglect and/or improper care. They also confirmed that all staff had not received annual training in 2015 up to July 2016, for safe transfers, skin and wound, and continence management.

The DOC confirmed that they did not act immediately to investigate, respond by notifying and disciplining identified staff where determined necessary, report to the Director, notify police, or re-train staff in a timely manner to protect all residents in the home from abuse,

neglect and/or improper care by staff identified in the evidence as having abused, neglected and/or provided improper care to resident #001. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home developed and implemented a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care services, programs and goods provided to residents.

A) The home's "Bella Senior Care Residence Quality and Risk Management Manual", last reviewed September 2011, included policies regarding the home's quality management systems and processes.

The "Quality Process" policy number 1.2 indicated that the home was to:
i) "select and/or modify the indicators, audits or projects that fit with the significant aspects of the departmental operations using the dimensions of quality;
ii) Set up a routine data collection method for each critical indicator as a Quality Plan;
iii) Record the monitoring results and provide some analysis;
iv) Initiate problem solving activities when variations are flagged and subsequently identified as a pattern or trend in the data;
v) Evaluate each indicator to determine the usefulness of the indicator (at least once per year); and

vi) Report the results of monitoring activities in a statistical and descriptive format to staff, teams and the Board."

In addition, the policy directed the home to utilize a "Plan-Do-Study-Act" cycle of quality improvement that included identification of processes needing improvement, analysis of causes of the problem, generating solutions, development and implementation of a plan to improve quality.

Review of the home's audits completed in 2016, indicated that the home had an audit schedule that was partially followed. The DOC confirmed that not all audits for 2016 had been completed according to the home's schedule, and that no data were generated, no trends identified, no analysis completed, no processes identified for improvement, no causes identified, no recommendations, improvement plans, or actions had been taken to address quality deficiencies or make improvements regarding all programs in the home.

B) The "Quality Committee" policy number 3.1 indicated that a Quality Committee should meet quarterly or more frequently at the call of the Chair. The Administrator was the designated Chair of the committee. The purpose of the Quality Committee included providing visible direction, co-ordination and ongoing development of the quality management program, philosophy and initiatives; and coordinating the review of quality indicators, trends, and issues occurring at the home.

During interview, the Administrator stated that they did not know when the Quality Committee had last met and did not know where to find the minutes of any Quality Committee meetings that had been held. The Administrator also stated they did not know if audits, data analysis, recommendations or implementation plans had been completed and suggested that the LTC Inspector ask the DOC for this information. The DOC confirmed that the home's Quality Committee had not met in 2015 and met once in 2016 in February/March.

C) The "Quality Committee" policy number 3.1 indicated that "The Management Company had delegated responsibility and authority to the Administrator of the Home. The Management Company receives reports and provides feedback to the Administrator on issues and accomplishments related to quality improvement. The Management Company directs, co-ordinates, and provides for ongoing development of the quality improvement philosophy and plan for the Home."

During interview on October 6, 2016, the Management Company's representative stated that they did not know when the last time the home's Quality Committee had met, and stated not knowing if or how the Quality Management Program was being implemented as of October 6, 2016 as required in the "Quality Committee" policy. [s. 84.]

***Additional Required Actions:***

***CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian**

**Specifically failed to comply with the following:**

**s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was at least one registered dietitian for the home who was a member of the staff of the home and was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The LTC Inspector requested the Registered Dietitian (RD) hours from the home's Administrator. The Administrator stated they had no knowledge of: the RD's weekly schedule, the RD's legislated on site hours and the contents or whereabouts of the contract between the home and the service provider of the RD. An interview with the Director of Care (DOC) revealed they had no knowledge of the RD's weekly schedule, the RD's legislated on site hours and the contents or whereabouts of the contract between the home and the service provider of the RD. The DOC provided the Inspector with paid invoices for the RD services for the months of August, September, November 2015 and April, May, June, and August 2016, which indicated a lump sum payment for

monthly RD services paid to Marquise Hospitality with no differentiation of hours worked or rate of pay. The Administrator provided a copy of an email correspondence, received from the Regional Director of Operations in Ontario, for Marquise Hospitality Group, on a specific date in 2016. The email confirmed the RD was the registered, licensed dietitian at Bella Long Term Care Centre, was an employee of Marquise Hospitality and had been contracted to work at the site 80 hours per month. The RD was described to have worked every Thursday for 10 hours, on site and made up the remaining 10 hours per week on one to two other days during the week/weekend. The RD confirmed they were on salary in the amount noted. Interview of the Food Service Manager revealed no knowledge of required, legislated on site RD hours, neither the existence of a contract for the RD service nor the weekly schedule of the RD. Interview of the RD revealed they had no knowledge of required, legislated hours to be on site in the home, the existence of a contract for the RD service to the home and the belief that the agreement between the RD and the employer of the RD to be "casual as needed" at the home. The home's licensed bed capacity was 161 beds. For the month of May 2016, occupancy was 159 residents and the required on site RD hours were 79.5 hours/month. June 2016 was 158 residents and the required on site RD hours were 79 hours/month. July 2016 was 161 residents and the required on site RD hours were 80.5 hours/month. August 2016 was 158 residents and the required on site RD hours were 79 hours/month and September 2016 was 161 residents requiring on site RD hours to be 80.5 hours/month. The occupancy for each of the five months was confirmed by the Director of Care. The RD was unable to confirm actual hours worked but did identify being on site five dates in May 2016, six dates in June 2016, six dates in July 2016, seven dates in August 2016, and seven dates in September 2016. If the RD had worked 10 hours on each day identified as being onsite then the RD would have worked 50 hours in May, 60 hours in each of June and July, and 70 hours in each of August and September. The RD confirmed they had not worked more than 10 hours on any day for the five months noted. The RD confirmed the remaining required hours were made up by offsite documentation. The RD stated they were not on site at the home for the required time of 30 minutes per resident per month. [s. 74. (2)]

***Additional Required Actions:***

***CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 005 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (2) The licensee shall ensure,**
**(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).**

**s. 229. (2) The licensee shall ensure,**
**(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure, (b) the interdisciplinary team that coordinated and implemented the Infection Prevention and Control program met at least quarterly.

The DOC stated the home's practice was for the interdisciplinary team to have met as part of the Professional Advisory Committee meeting (PAC) on a quarterly basis. The DOC was unable to provide documentation supporting Infection Prevention and Control quarterly meetings occurred at the PAC.
The DOC confirmed that the interdisciplinary team, that coordinated and implemented the Infection Prevention and Control program, had not met at least quarterly as part of the Professional Advisory Committee in 2015. [s. 229. (2) (b)]

2. The licensee has failed to ensure, (e) that a written record was kept relating to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A review of the home's records did not indicate the program was evaluated and updated at least annually in accordance with evidenced-based practices and, if there were none, in accordance with prevailing practices. Interview with the DOC confirmed that the Infection Prevention and Control program was evaluated and discussed at quarterly Professional Advisory Committee (PAC) meetings however there was no record kept related to the evaluation. The DOC confirmed the licensee failed to ensure that (e) a written record was kept relating to each evaluation under clause (d) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 229. (2) (e)]

3. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program during the provision of care of resident #001 .

A) During a review of the evidence it was identified that on several identified days in November 2015, December 2015 and January 2016, several identified staff members had not participated in the implementation of the home's Infection Prevention and Control program when the staff had not followed or implemented measures or directions to prevent the transmission of infections.
Specified actions observed included:
i) Inconsistent use and changing of gloves during the provision of care.
ii) Lack of hand hygiene.
iii) On several occasions had thrown soiled briefs and unclean linens onto the resident's floor during the provision of care.

Interview with PSW #104 confirmed that "all" PSWs throw soiled briefs and linens on the floor during the provision care and pick it up off the floor at the end of the care. They stated this practice had not followed the home's Infection Prevention and Control program as soiled briefs were to be placed in the garbage and soiled linens directly in hampers. Interview with PSW #116 confirmed that inconsistent use of and changing of gloves, inconsistent washing of hands between points of care, were not supportive of hand hygiene that was part of the home's Infection Prevention and Control program.

A review of the home's internal documents on September 27, 2016, confirmed that eight PSW members ( #111, #116, #120, #125, #128, #129, #131, #132) had not followed the home's Infection Prevention and Control program. (511)

B) Review of evidence on several identified dates in November 2015, December 2015, and January 2016, indicated that PSWs #104, #115, #116, #117, #118, #124, #128, #129, and #132 and RN #122, had not participated in the implementation of the home's Infection Prevention and Control program during the provision of care of resident #001.

Actions included lack of hand hygiene during the provision of care, using bedding that had been placed on the floor and improper use of equipment.

Interview with the DOC confirmed the licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program during the provision of care for resident #001. (526) [s. 229. (4)]

***Additional Required Actions:***

***CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 006 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

According to resident #001's health records they were cognitively impaired and demonstrated responsive behaviours

(b) Strategies not implemented.
The written plan of care, printed in August 2015, and available to staff between November 2015, and February 2016, provided staff with ten descriptive strategies to implement when providing resident care to reduce the resident's responsive behaviours

Review of evidence between November 2015 and February 28, 2016, indicated that the resident demonstrated behaviours during approximately 40 care occasions and that PSWs #104, #111, #112, #117, #118, #121, #124, #127, #128, and #132 had not implemented the strategies that had been developed to manage behaviours.

During interviews, PSWs #104, #112, #116, #120, #125, and #128 confirmed that the resident had responsive behaviours. They confirmed they had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours. During interview, RPN #135 stated that resident #001 would demonstrate responsive behaviour if care was not provided as directed in the plan of care. RPN #135 also stated that they observed PSWs #104, #121, #125 and #128 providing rushed care to resident #001 and without speaking with the resident and had instructed PSWs to re-approach if the resident was not happy.

PSWs #104, #112, #118, and #128 stated that they cared for the resident in a specified manner since they thought that the approach was expected of them in the course of providing care given the resident's responsive behaviours; they stated not knowing this was wrong. All PSWs confirmed that the resident appeared to be in distress through facial grimacing and tone of voice as they provided care while not implementing strategies identified in the plan of care to manage these behaviours.

During interview, the DOC stated that PSW staff had not followed resident #001's plan of care, or implemented strategies developed to manage responsive behaviours. They confirmed that staff not implementing the strategies contributed to the resident's distress and escalation of behaviours during their care.

(c) Actions not taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The home's "Responsive Behaviour Management" policy Section 4.11.10, last reviewed June 2013, located in the Bella Senior Care Resident Services Manual, directed staff to do the following with residents that exhibited "Complex/Difficult/Responsive Behaviours":
i) Initiate behaviour documentation in the resident's record for a 7 day period,
ii) Hold interdisciplinary conference to be planned at the end of 7 day time period to review the behaviour tracking record,
iii) The Interdisciplinary team will analyze behaviours that occurred to identify triggers and consequence of the behaviour if possible,
iv) Continue to monitor behaviour and effect of interventions,
v) If behaviours continued, review with physician to obtain a consult for psychogeriatric assessment,
vi) Notify psychogeriatric team regarding the issue and provide a copy of the behaviour flow sheet, and
vii) Continue monitoring and documenting the resident's behaviours.

Review of resident #001's health record and interviews with PSWs #104, #112, #116, #118, #120, #125, and #128 revealed that the resident had cognitive impairment and demonstrated responsive behaviours. The DOC confirmed that the resident exhibited "Complex/difficult" behaviours according to the home's policy. The plan of care last revised in August 2015, directed staff to implement at least 10 different strategies for the management of their behaviours.

Review of resident #001's health record indicated that the most recent assessment by Behavioural Supports Ontario (BSO) had been in 2012. The DOC could not state when the last referral or completed assessment of resident #001's behaviours had been. During interview, RPN #135 stated that BSO had not been involved with resident #001's care for at least two years. Review of the progress notes indicated no entries regarding responsive behaviours between November 1, 2014 and February 28, 2016. The DOC and ADOC confirmed that PSW staff should have notified registered staff of resident #001's behaviours and registered staff should have documented these issues in the progress notes. Notes written by the resident's physician between February 2015 and February 2016, indicated that the resident's behaviours had settled down and there were no new issues.

Review of the resident's health record did not reveal behaviour documentation such as the use of the Direct Observation Sheet (DOS) charting and the DOC was unable to confirm if or when it was completed last. Although the plan of care was updated in August 2015, the DOC confirmed that an interdisciplinary conference and/or behaviour team meeting were not held for management of resident #001's responsive behaviours according to the home's policy, that there was no evaluation or analysis to identify other strategies, and that staff had not documented the behaviours observed according to the home's policy.

During interview, PSWs #104, #112, #118, #125, and #128 stated that while they had not followed the plan of care, they had reported difficulties providing care and had been told by registered staff on numerous occasions to get the care done. In evidence provided by the resident's family member between November 2015 and February 2016, PSWs were observed providing care, without implementing identified intervention for responsive behaviours. The PSWs interviewed uniformly stated that they did not think that the care provided and the approach used was improper and stated that they continued to care for residents using the approaches that were identified as improper until they were educated in 2016.

The home failed to take actions, including assessments, reassessments and interventions, as described in their Responsive Behaviour program, into the plan of care for resident #001 to ensure that their care was based on their assessed needs and that the resident's responses to interventions were documented. [s. 53. (4) (b)]

***Additional Required Actions:***

***CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any person who had reasonable grounds to suspect any of the following had occurred or may have occurred shall immediately report the suspicion upon which it was based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm of risk of harm to the resident.

In June 2016, the MOHLTC received a complaint (# 019456-16), from a family member that indicated they had evidence that revealed resident #001 had been abused. The family member alleged the home had done nothing or taken no action when they were notified of the allegation of abuse to resident #001. In 2016 the MOHLTC received a Critical Incident Report (CI) # 2890-000028-16 from the home. A review of the CI # 2890 -000028-16, submitted by the DOC, in 2016, confirmed the Long Term Care home received a complaint of poor care and had been investigating for potential abuse of resident #001. The CI report indicated the date and time of the alleged incident was the same as the date reported to the Ministry Of Health and Long Term Care (MOHLTC).

A review of the home's documentation and interviews were conducted to confirm the date and time that anyone whom had reasonable grounds to suspect:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident,

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm of risk of harm to the resident, had occurred or may have occurred; and if the suspicion upon which it was based was immediately reported to the Director.

A review of an Amendment Agreement, dated February 28, 2014, for Bella Senior Care Residences Inc. ("the licensee") and Assured Care Consulting Inc. ("the Manager") was completed. The licensee had entered into a management contract with the Manager whereby the Manager was proposed to manage and operate the Home on behalf of the Licensee. This contract confirmed a management agreement for a further five years commencing on March 1, 2014. It was confirmed, through an interview with the president of Assured Care Consulting Inc., that the Manager role and responsibility was for the oversight of all aspects of management in order to ensure legislative compliance for the 161 bed Long Term Care home ("the home") at the time the allegation of abuse had been received.

On August 9, 2016 a request for any and all notes, which included investigative notes, interview notes, hand written notes that pertained to the allegation of abuse for resident #001 and any response to the allegations created by any and all staff of the licensee and Assured Care Consulting was requested and reviewed.

The following was a timeline of notification of the suspected abuse:
1. An interview with the family member confirmed they contacted a member of the home, at an unidentified date near the end of March, 2016 and stated their family member had been abused. The family member confirmed they notified staff #103 of the allegation of poor care and neglect from staff members at the home to resident #001.

2. Interview with the staff member confirmed they were contacted by the family member and were made aware of the allegation of poor care and neglect to resident #001 at an unidentified date in March, 2016. Staff #103 described that they had seen evidence that indicated a Personal Support Worker (PSW) abused a resident. Staff #103 described the resident as unable to express their needs and that the resident's face seemed to be scared and that they were not covered properly. Staff #103 stated to the family member they needed to report this to their Director of Care (DOC) and staff #103 confirmed they told the DOC approximately one week after they viewed the evidence of the alleged abuse. Staff #103 stated they offered to call the Ministry of Health, but the DOC told staff #103 they would "take it from there".

3. Interview with the DOC confirmed they were informed, by staff #103, in March 2016, of

the evidence indicating a potential abuse for resident #001. The DOC stated they followed up with a telephone call to the family member six days later, to gather more information of the allegation. The DOC stated the family member alleged concerns regarding the care of resident #001, on the date of the phone call, and received further evidence 11 days later. The DOC confirmed receipt of the evidence and stated they did not review the evidence provided by the family member until later that same week. The DOC stated that they reviewed a portion of the evidence, with the Administrator, and witnessed concerns of neglect to resident #001. The DOC stated they reviewed the evidence with the Nurse Consultant and the Manager (Assured Care Consulting Inc.) the following month. The DOC confirmed that the evidence demonstrated staff had abused resident #001.

The DOC had management responsibility for the LTC home as the DOC must supervise and direct the nursing staff and personal care staff of the long term care home and nursing and personal care provided by them. The DOC confirmed they had reasonable grounds to suspect resident abuse, neglect and or improper care of resident #001, but had not reported to the Director, until May 2016, when a CI report was submitted.

4. The DOC confirmed they notified the Director when they submitted a CI report to the MOHLTC in May 2016, 68 days after the initial allegation was reported to the home and one week after viewing evidence that confirmed resident abuse. The DOC confirmed that staff identified in the evidence provided, that were alleged to have committed resident abuse, continued to work with cognitively impaired residents during the 68 days when management of the home had reasonable grounds to suspect a potential resident abuse.

5. The Administrator confirmed they had knowledge of staff #103 coming forward with concerns of alleged abuse. The Administrator confirmed they viewed evidence provided by the family member with the DOC. The Administrator stated they confirmed evidence of staff abusing resident #001.

The Administrator had management responsibility for the LTC home as the Administrator must be in charge of the long-term care home and be responsible for its management. It was confirmed by the Administrator they did not report to the Director that they had reasonable grounds to suspect a potential resident abuse, neglect and/or improper care, and specifically did not report on or prior to an identified date in April 2016.

6. Interview with the Manager (Assured Care Consulting) confirmed they were contacted

by the family member on a specified date in May 2016 regarding care concerns for resident #001. The Manager agreed to meet with the complainant nine days later where they were informed, by the family member, of their concerns related to care and potential abuse to resident #001. The family member indicated they had evidence of abuse and confirmed the evidence had been previously provided to the DOC and Administrator and that no action had been taken. The Manager stated they notified Assured Care Consulting, Nurse Consultant (NC) to the home, the following day, to assist with reviewing the evidence. The Manager coordinated an onsite meeting approximately one week later, where the Manager, Nurse Consultant, DOC and Administrator reviewed the evidence.

As per the management contract in force between the Manager and the licensee, the Manager had management responsibility for the LTC home. The Manager confirmed they did not report to the Director that they had reasonable grounds to suspect a potential resident abuse, neglect and or improper care, and specifically did not report on or prior to the several identified dates in May 2016 nor did they ensure the Administrator or DOC had reported to the Director as they were required to do by the management contract entered into pursuant to s. 110 of the Act which they are required to comply with as a condition of the license as per s.101 (3) of the Act.

7 . Interview with the Nurse Consultant (NC), to the home, confirmed they received a call on an identified date in May 2016, from the Manager regarding an allegation of abuse and that there had been evidence provided to the home. The NC stated they received a follow-up email from the Manager regarding the alleged abuse of resident #001 and scheduled a meeting at the home to review the evidence. The Nurse Consultant stated they reviewed the evidence in May 2016, which, in their opinion, constituted both physical and emotional abuse to resident #001. The NC stated they reviewed the evidence that demonstrated resident #001 was abused. The staff had been further described as neglecting the resident. The NC stated they inquired if the DOC had notified the Director through a CI report and confirmed they had not ensured this was completed at that time.

8. Interview with the President/Director for the Licensee confirmed they had become aware of the allegation of abuse near the end of March or early April at an unidentified date. They confirmed they became aware of the provision of evidence approximately two weeks after the date they became aware of the alleged abuse.

The President/Director was responsible for the management and operation of the LTC

home. The President/Director did not report to the Director that they had reasonable grounds to suspect resident abuse, neglect and/or improper care, and specifically did not report on or before mid-April 2016 by which time they had become aware of the evidence of alleged abuse, neglect and /or improper care. [s. 24. (1)]

***Additional Required Actions:***

***DR # 007 – The above written notification is also being referred to the Director for further action by the Director.***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any person who has reasonable grounds to suspect any of the following has occurred or may have occurred shall immediately report the suspicion upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm of risk of harm to the resident, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

According to their health record, resident #001 had cognitive impairment, and required assistance from staff for their activities of daily living. Review of evidence provided between identified dates in November 2015 and February 2016, indicated that PSW staff repeatedly failed to fully promote and respect resident #001's privacy in treatment and care.

PSW #112 confirmed that the resident appeared cold and frightened during the provision of care. PSW #128 confirmed that the resident should have been partially covered during care to promote their privacy. PSWs #112 and #118 confirmed that the resident was attempting to cover themselves and had a distressed look on their face. PSWs #112, #118, #128, and the DOC confirmed that staff had failed to fully promote and respect the resident's right to privacy in treatment and in caring for their personal needs. [s. 3. (1) 8.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs is fully respected and promoted, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

A) In accordance with Regulation, s. 50 (2), paragraph (d), required any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

The home's Wound and Skin Care Program, policy, Section: 4.16, Subsection: 4.16.1 revised May 2016, located in the Bella Senior Care Resident Services Manual, directed staff to reposition dependent residents a minimum of every two hours during waking, including chair position and a minimum of two times per night. The DOC confirmed that resident #001 was clinically required to receive care as described in the home's Wound and Skin Care program. A review of the Point of Care (POC) schedule of interventions for resident #001 directed staff to turn and reposition the resident every shift. For the months of November and December 2015 and January and February 2016, there was no documentation on any day over this period indicating the task had been completed. Interview of RN #101 on October 4, 2016, confirmed the task was not done for the months reviewed as there was no documentation that indicated it had been completed.

B) In accordance with Regulation, s. 68 (2), paragraph (d), required every licensee of a long-term care home to ensure that the Nutrition care and hydration programs include (d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The home's Feeding and Hydration program Section: 4.9 subsection 4.9.1 revised June 2015, located in the Bella Senior Care Resident Services Manual, directed staff to compare the fluid intake record in Point of Care (POC) daily to determine if the resident had met their fluid needs for the day. Resident #001 was assessed by the Registered Dietitian (RD) and required a specific amount of daily fluid intake as documented in the written plan of care dated October 2015. According to the home's policy when a resident did not meet their fluid needs for the day, the Registered staff were to assess the resident for signs of dehydration and document results of the assessment in the resident record. If the resident's fluid intake was below their fluid needs for three consecutive

days, the resident was to be placed on a fluid watch. The Registered staff were to have activated this task in POC to alert the staff to prompt extra fluids. A dietary referral was to be made to notify the RD that the fluid watch had commenced. A report run by RPN #102, from POC, indicated that on three consecutive days in November 2015, resident #001 was below their assessed fluid needs for each day. There was no referral sent to the RD, no task activated in POC nor any documentation of the assessment for dehydration by a Registered staff. The DOC confirmed there was no referral, assessment or task assigned for resident #001 related to a three day decrease in fluid intake. During interview the DOC confirmed the licensee failed to ensure the home's Feeding and Hydration policy was complied with.

C) In accordance with Regulation, s. 51 (2), paragraph (a), required the licensee to ensure each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The home's Continence Care and Bowel Management Program, policy, Section: 12, Subsection: 12.1, revised December 2015, located in the Bella Senior Care Resident Services Manual, directed staff to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument on admission, quarterly and after any change in condition that may affect bladder or bowel. RN #101 and RPN #102 confirmed the home did not have a bladder continence assessment tool other than what was contained in section "H" of Minimum Data Set (MDS). The DOC confirmed the home did not have a bladder continence assessment tool other than what was contained in section "H" of MDS and that the home's Continence Care and Bowel Management policy had not been complied with. (640)

D) In accordance with Regulation, s. 36, required the licensee to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home's Transfer and Mobility, Safe Handling and Assessing Residents policy, Section: 4.6.1, last reviewed January 2015, located in the Bella Senior Care Resident Services Manual indicated the following:
i) "Each employee will attend yearly refresher training on the use of equipment"
ii) The SHARP Leader will conduct yearly competency and skills audit in order to ensure the highest level of competency by the employees; and

iii) "Any employee who does not pass will be re-educated and retested. While this process is taking place that employee must be paired with an employee who has passed their audit".

Resident #001's family member provided evidence to the home in April 2016 for an identified time period between November 2015 and February 2016. The evidence demonstrated that on at least seven days, at least 10 PSW staff used unsafe transferring techniques for resident #001 that contributed to the resident's distress and risk for injury. On at least four days, six staff were observed using unsafe techniques while roughly turning and positioning resident #001 during care. During turning and repositioning, the resident demonstrated a grimacing facial expression and an increase in their verbalizations.

Review of the home's training records and interview with the DOC confirmed that not all employees had attended the annual refresher training for safe handling and assessing residents according to the policy. In addition, the DOC confirmed that the home had not followed the policy to conduct yearly competency and skills audits to ensure staff competency, and that staff who were not competent were not being paired up with staff who had passed an audit. (526)

E) In accordance with Regulation, s. 114 (2), required the licensee to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's Pharmacy Services, policy, Section 8.0, Subsection 8.3, Documentation, last reviewed January, 2010 and located in the Bella Senior Care Residence Resident Services Manual directed staff to do the following:
The procedure for ordering medications using the physicians order sheet stated that "once the physicians orders had been written, the E-PEN was to be placed securely in the portal and observed for the transmission signal". All new medications were to be placed in the appropriate section of the computer. The Physicians Orders were to be processed by a registered staff member (first check) and then checked by another registered staff (second check), inputted into the computer and sent to pharmacy through the electronic record.

A review of the clinical record for identified dates in February 2016 indicted physician orders were received and had not been processed by a registered staff member (first

check), checked by another registered staff (second check), inputted into the computer or sent to pharmacy through the electronic record. RN #147 reviewed the Physician's Digiorder form, the electronic Medication Administration Record (eMar) and confirmed the physician's orders had not been processed. Interview with the DOC confirmed the licensee failed to ensure the home's policy for ordering and processing physician's orders as described in the home's Pharmacy Services policy was complied with (511) [s. 8. (1) (a),s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is (b) complied with. This is specific to the home's:***
***1. Wound and Skin Care,***
***2. Feeding and Hydration,***
***3. Continence Care and Bowel Management,***
***4. Transfer and Mobility, Safe Handling and Assessing Residents,***
***5. Pharmacy Services plan, policy, protocol, procedure, strategy or system, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's written policy that promoted zero

tolerance of abuse and neglect of residents was complied with.

The home's "Abuse and Neglect Prevention" policy number 4.1.2 last reviewed January 2013, located in the home's Resident Services Manual directed "Any person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to their Supervisor, the Director of Care or the Administrator: 1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident; 2. Abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident."

A) Staff #103 confirmed during interview that they did not immediately report their suspicion of abuse or neglect of resident #001 to the DOC when they reviewed evidence of care received by resident #001. The staff member confirmed that they suspected abuse after reviewing the evidence and that they did not report their suspicion until approximately one week after reviewing the evidence.

B) Evidence dated between November 2015 and February 2016, indicated that PSW staff had emotionally, verbally and physically abused resident #001 with a number of these in the presence of another PSW staff. PSW staff #104, #112, #116, #118, #120, #125, and #128 were interviewed and confirmed that they had not immediately reported abuse that they had witnessed according to the home's policy. During interview, staff were not readily able to repeat definitions of abuse or their complete responsibilities as outlined in the home's policy, but were able to identify abuse while reviewing the evidence during the interview.

When interviewed, PSW #128 stated that they had not reported the verbal abuse to their supervisor, DOC or Administrator according to the home's policy.

1. Evidence for an identified date in December 2015, indicated that PSW #128 witnessed PSW #117 complete an act that was abusive to resident #001. PSW #128 confirmed that it could be interpreted as emotional abuse and that they had not reported the abuse to their supervisor, DOC or Administrator according to the home's policy.

2. Evidence for an identified date in December, 2015, indicated that PSW #117 witnessed PSW #128 abuse resident #001. PSW #117 was not available for interview. The DOC stated PSW #117 should have reported the actions of PSW #128, as witnessed in the evidence, to their supervisor, the DOC or Administrator according to the

home's policy.

3. Evidence for an identified date in November 2015, indicated that PSW #112 witnessed PSW #118verbally abuse resident #001. During interview, PSW #112 confirmed that PSW #118's comments were emotional abuse upon resident #001 and that they did not immediately report the abuse to their supervisor, DOC or Administrator according to the home's policy.

4. PSW staff repeatedly neglected and abused resident #001. PSWs #104, #112, #116, #118, #120, #125 and #128 confirmed that this was emotional abuse and that they had not immediately reported these instances to their supervisor, the DOC or the Administrator according to the home's policy.

During interview, the DOC confirmed that PSW staff had not reported abuse according to the home's policy when there was a reasonable grounds to suspect that they had witnessed abuse. [s. 20. (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 to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knew of, or that was reported was immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations.

According to health records, resident #001 had cognitive impairment. Their Resident Assessment Instrument Minimum Data Set (RAI MDS) completed in January 2016, indicated that they required assistance from two staff persons for care. The resident exhibited responsive behaviours.

On an identified date in 2016, resident #001's family member submitted a complaint to the Ministry of Health and Long Term Care (MOHLTC) that alleged that their family member had been abused and neglected when they received care in the home. The family member also expressed concern about care provided during the last three days of the resident's life in that the resident was not assessed or provided care for a period of time, and was not made aware of changes in care implemented without the Substitute Decision Maker's (SDMs) consent. The family member stated that evidence of the alleged poor care that resident #001 had received between November 2015 and February 2016 had been given to the Administrator and DOC.

This inspection revealed the following:

A) During interview in August 2016,staff #103 confirmed that they met with resident #001's family member. Staff #103 described to a LTC Inspector actions, that they had reviewed during that meeting, that was suspected abuse. According to the staff, the family member told them that there was more evidence about the care that resident #001 received while living at the home. The staff confirmed that they suspected abuse after reviewing the evidence and that they did not immediately initiate an investigation of alleged, suspected or witnessed abuse or report the suspected abuse to anyone at the home so that the investigation could be initiated.

B) During interview with staff #103, on an identified date in August 2016, they confirmed that they reported the suspected abuse, to the DOC, approximately one week after viewing the evidence provided by the family. During interview with the DOC on and identified date in September 2016, the DOC confirmed that staff #103 reported on an identified date in March 2016, that they reviewed evidence provided by resident #001's family member that demonstrated "what looked like abuse" and improper care of resident #001. The DOC stated that she left the home without immediately initiating an investigation of alleged, suspected or witnessed abuse.

C) During interview with the DOC in September 2016, the DOC stated that on an identified date in March 2016, they clarified information with staff #103, and called resident #001's family member several days later in March 2016. Notes dated in March 2016, made by the DOC during the telephone call were reviewed. During an interview with the DOC they stated that during the telephone conversation, resident #001's family member expressed concern that resident #001 had been abused and received improper care between November 2015 and February 2016. A follow up meeting was scheduled with resident #001's family member in April 2016. The DOC confirmed that they were not certain if abuse had occurred but had not immediately initiated an investigation of abuse, alleged by the family member in March 2016, and wanted to wait until the meeting in April 2016, with the family member to gather more information about the complaint.

D) During interview on September 8, 2016, the DOC confirmed that they and the Administrator met with resident #001's family member in April 2016 and that they were provided with evidence of the alleged abuse. Several written examples of the alleged abuse where contained in the notes provided by the DOC. The DOC confirmed they were an accurate reflection of what was told to them by resident #001's family member. The DOC confirmed that they suspected abuse at that time and that they did not immediately initiate an investigation of alleged, suspected or witnessed abuse on April 2016. The

DOC confirmed that after the identified date in April 2016, they did not review further evidence again or act on knowledge of suspected abuse until late in May 2016.

During interview, with the home's President/Director/Licensee in September 2016, they confirmed that an investigation of alleged, suspected or witnessed abuse of resident #001 had not been immediately initiated on or before an identified date in March when staff #103, the DOC and the Administrator became aware of allegations of abuse and improper care of resident #001.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:***
***(i) Abuse of a resident by anyone***
***(ii) Neglect of a resident by the licensee or staff, or***
***(iii) Anything else provided for in the regulations, to be implemented voluntarily.***

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, except that a resident should only be repositioned while asleep if clinically indicated.

A review of evidence, revealed that on at least six occasions between November 2015 and December 2015, resident #001 had not received care for several hours during identified shifts. Resident #001, who was dependent on staff for bed mobility, was not turned or repositioned by staff. An MDS assessment identified resident #001 to be dependent on two staff for bed mobility as documented in the written plan of care, dated October 2015. Interview of PSW #123 confirmed the resident required two people for bed mobility. PSW #123 confirmed resident #001 should have been turned or repositioned and that this was not always carried out. The DOC confirmed resident #001's condition was such that it was clinically indicated for this resident to be turned or repositioned as identified. [s. 50. (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 to ensure that a resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, except that a resident should only be repositioned while asleep if clinically indicated, to be implemented voluntarily.***

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

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

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

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

Resident #001's RAI MDS assessment, completed in October 2015, indicated that the resident was incontinent during the previous 14 day observation period. The RAI MDS assessment completed in January 2016, revealed a deterioration in continence.

The home's "Continence Care and Bowel Management Program" policy number 12.1 last reviewed December 2015, directed staff to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument after any change in condition that may affect bladder or bowel.

Review of resident #001's health record indicated that they had not had a continence

assessment using a clinically appropriate assessment instrument since their admission. During interview in September 2016, RAI MDS staff confirmed that the home did not use a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence for resident #001
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During interview, the DOC confirmed that residents who were incontinent should be assessed using an instrument specifically designed for that purpose where the condition applies. [s. 51. (2) (a)]

2. The licensee has failed to ensure that a resident who required continence care products was provided with a range of continence care products that, (i) were based on their individual assessed needs, (ii) properly fit the residents, and (iii) promoted resident comfort, ease of use, dignity and good skin integrity.

Resident #001's RAI MDS assessment completed in October 2015, indicated that the resident was incontinent during the previous 14 day observation period. The home's assessment completed in January 2016, indicated that the resident's continence had deteriorated. The written plan of care printed in August 2015, and available to staff in a binder at the nurse's station between November 2015 and February 2016, indicated that resident #001 required an incontinent product, based on their assessed need, at all times and they were to be toileted at identified times and as needed (PRN). The resident was also identified as being at risk for skin breakdown. The plan of care did not include the use of alternative continence products.

Review of evidence for several identified dates in November 2015, December 2015; and January, 2016, indicated that staff (PSWs #112, #116, #120, #124, #128,and #132) applied continence care products that were not based on the resident's assessed needs, did not properly fit the resident, and did not promote resident comfort, ease of use, dignity and good skin integrity.

Interview with PSWs #116, #120, #124, and #128, confirmed that staff used alternate products to manage resident #001's continence. PSW #112 stated that they thought that it was part of the plan of care, and PSW #116 stated that the resident could demonstrate responsive behaviours when continence care was provided. According to staff interviewed, using the non assessed continence products would diminish the number of brief changes required and was more convenient for staff. Staff stated they could not confirm that the strategies outlined above promoted resident comfort, ease of use, dignity and good skin integrity.

Interview with the DOC in September 2016, confirmed that staff should not have been using the non assessed continence products for resident #001. The DOC stated they could not verify that the strategies used by PSWs promoted resident comfort, ease of use, dignity and good skin integrity. [s. 51. (2) (h)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident requires, to be implemented voluntarily.***

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**WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

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

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff had received retraining annually relating to the Resident's Bill or Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protection.

Review of the home's education and training files for 2015, and interview with the DOC confirmed that not all 219 staff in the home had received annual retraining relating to the Resident's Bill or Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protection. [s. 76. (4)]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the area set out in the following paragraphs, at times or at intervals provided for in the regulations: (5) Palliative Care

As per regulation 221 (2), (1) The licensee shall ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following: the staff must have received annual training in all areas required under section 76 (7) of the Act.

(5) Palliative Care:
A review of the 2015 annual training records, confirmed by RPN #102, indicated only two staff members attended a Fundamentals in Palliative Care course offered at the home. RPN #102 stated there had been no individual assessed needs of staff members and the training was intended and offered to all staff in the home. The homes' staffing complement of direct care staff was approximately 101 personal support workers and 38 registered staff. An interview with the DOC confirmed that 1.96% staff had received annual training in Palliative Care from the home and the homes' staffing complement was approximately 139 direct care staff members in 2015. Pain Management in Palliative Care was provided to registered staff in March of 2016 with 14 (36.84%) of the 38 registered staff attending. The DOC confirmed the licensee failed to ensure the staff received annual training in Palliative Care as per the regulation. (511) [s. 76. (7) 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance will ensure that staff receive retaining annually relating to the Resident's Bill or Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protection, to be implemented voluntarily.***

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**WN #17: 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 (a) drugs were stored in an area or a medication cart, (ii) that was secure and locked.

A review of evidence from an identified date in February 2016 was completed. The evidence identified resident #001 received medication from the home's staff member. Specifically, a registered staff member entered resident #001's room and placed equipment and non secured medications and supplies in the resident's room. The evidence determined that another person, not employed by the home, was in the room.

The evidence identified the nurse exited the resident's room and left the medication unsecured and commented to the person in the room to not let anyone take the medication. The registered staff then left the equipment, medication and supplies unattended and not in a locked area or medication cart. The evidence further identified the registered staff returned to resident #001's room and assessed the resident. The registered staff then stated to the resident that the medication would be given to them to make them feel more comfortable. The registered staff then took the same medication, that was left unsecured earlier, and administered the medication to resident #001.

Further review of the eMAR written record for the identified date in February 2016 indicated that controlled medications were signed as administered, during the time period identified above, by RPN #135. It was confirmed through the review of the evidence and the corresponding eMar that the medications were not secured and locked when they were stored in the resident's room on the identified date in February 2016 [s. 129. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked, to be implemented voluntarily.***

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the clinical record for resident #001 indicated, on an identified date in February 2016, a physician's order for medication changes had been received based on the resident's change in condition. The physicians orders were documented and processed on the Physician's Digorder record.

On a different identified date in February 2016 a physician order was received to cancel the previous orders and to resume all previous medications.

Further review of the electronic medication administration record (eMar) indicated that on four separate occasions, after the change in physician orders in February 2016, medications were signed for as administered without a physician's order.

Interview with staff #147 confirmed the specified order had been discontinued and the previous order for the medications should have been given

Interview with the DOC confirmed the licensee failed to ensure medications, had been administered to resident #001 in accordance with the directions for use specified by the prescriber on an identified date in February 2016. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review of the clinical record indicated resident #001 had a change in their condition on an identified date in February, 2016. New physician orders were received that included treatment modalities and medications that required staff to continue to monitor the resident for any further change in status. The last progress note described the resident to be 'comfortable' and required treatment with medications. The next progress note was for the following day when the resident was described to have a change in their condition. Interview with the SDM stated that a family member was present during these hours and stated the RPN had not come back into the room to assess the resident after the administration of medications. A review of the electronic medication administration record (eMar) identified the resident had received a specified number of doses of an analgesic during the two identified days referred above. There was no documentation in the progress notes or the eMar to indicate the monitoring and documentation of the resident’s response and the effectiveness of the medications given during this period A review of the home's pain management policy confirmed residents would be assessed and reassessed for pain and that the assessments should be documented carefully so other staff could refer to the notes. Interview with RN #147 confirmed the home's practice would have been to monitor and document the effectiveness of the medications. RN #147 confirmed the absence of this documentation in the clinical records reviewed. The DOC confirmed the licensee failed to ensure that when resident #001 had received a drug or combination of drugs, there was monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs. [s. 134. (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.***

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure a plan of care was based on, at a minimum, interdisciplinary assessment of the resident's sleep patterns and preferences.

A review of evidence indicated that staff were unaware of sleep and rest patterns for resident #001. On at least six occasions, staff had not provided care for several hours during the night. Review of resident #001's written plan of care, referred to by the home as the Kardex, printed in August 2015, revealed that there was no focus related to sleep patterns and preferences nor was there any direction given to staff of what those preferences were for resident #001. In September 2016, PSW #123 confirmed staff were not aware of resident #001's sleep patterns and preferences. In October 2016, the DOC confirmed that sleep patterns and preferences were not included in resident #001's written plan of care. [s. 26. (3) 21.]

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The dietary services and hydration program was not evaluated annually. The Resident Services Manual, Section: 4.9 Feeding and Hydration, Subsection: 4.9.1 Feeding and Hydration, approved by the Director of Care and revised June 2015, was not evaluated annually as confirmed by the Director of Care. The Registered Dietitian for the home confirmed the RD did not have input into the program "Feeding and Hydration" with a revised date of June 2015. [s. 30. (1) 3.]

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.

In April 2016, resident #001's family member complained to the DOC that they observed staff #107 walk past a resident who fell and had not assisted them. The DOC confirmed that they had not initiated an investigation of this complaint according to legislative

requirements. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record of every complaint is kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

The home's "Concerns, Issues, and Complaints" policy number 4.2.10 (last reviewed March, 2016), directed staff to use the "Suggestions, Concerns and Complaint Form" when documenting complaints concerning the care of a resident or operation of the home.

According to staff, complainant interviews, and notes provided by the home, the following complaints were made in the home concerning the care of a resident or operation of the home.

A) Prior to March 2016, staff #103 received a complaint from resident #001's family member that resident #001 may have been abused andstaff #103 reported this to the DOC in March 2016. According to notes, provided by the home and interviews with the DOC and Administrator, the DOC contacted the complainant by phone in March 2016. According to the DOC, during this phone conversation, the SDM stated that they wanted changes made in the home in response to their complaint about abuse toward their family member.

The DOC and Administrator then met with the complainant in April 2016, at which time the complainant provided evidence that revealed care that resident #001 had received between November 2015, and February 2016. The family member complained that resident #001 had been abused, neglected and received improper care between November 2015 and February 2016. The SDM told LTC Inspectors during interview that they felt that there were operational issues in the home including following up on complaints and preventing abuse.

Interview with the DOC in September 2016, confirmed that the "Suggestions, Concerns and Complaint Form" was not used to document this complaint of alleged abuse and improper care of resident #001. The DOC stated that they did not maintain records of dates and description of responses between the home and the complainant after the initial meeting with the complainant. Interview and notes provided to inspectors indicated that the complainant had made efforts to obtain information from the home about the investigation and since they had not received a reply, contacted the home's management company for more information.

B) In April 2016, resident #001's family member (their SDM) also complained that identified nursing interventions had been initiated for resident #001 without the SDM's consent. The SDM also complained that resident #001 received improper care in that they were not immediately assessed when their condition changed, and the SDM couldn't find staff when they arrived to the home on an identified date in February 2016. During interview, the DOC stated that they investigated the complaint but did not document the details of the investigation including the final resolution, or any communication they had with the complainant.

C) In April 2016, resident #001's family member complained to the DOC that PSW #128 saw resident #003 fall from their chair and the chair alarm went off for 15 minutes.

D) In April 2016, resident #001's family member complained to the DOC regarding staff behaviours.

E) The home had received a written complaint from resident #001's SDM in December 2015 regarding specific care concerns.The DOC stated that they could not verify if the complaint had been resolved in 24 hours and had not documented the complaints management according to the home's policy or legislative requirements.

F) The home received a complaint by RPN #135 in February 2014, concerning care provided by PSW staff #121, #125, #127, and #128. The DOC confirmed that they investigated, the issues were not resolved in 24 hours and they had not documented as per their complaints management process according to the home's policy or legislative requirements.

G) A written complaint was made by RPN #135 that issues that had been previously raised by the RPN were again raised by the family of resident #002 at a care conference.

During interviews in September 2016 and October 2016, the DOC, confirmed that they investigated the complaints made by family and staff, that these complaints were not resolved within 24 hours and stated that they did not document the management of complaints according to legislative requirements. [s. 101. (2)]

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).**
**2. A description of the individuals involved in the incident, including,**
**i. names of all residents involved in the incident,**
**ii. names of any staff members or other persons who were present at or discovered the incident, and**
**iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**
**3. Actions taken in response to the incident, including,**
**i. what care was given or action taken as a result of the incident, and by whom,**
**ii. whether a physician or registered nurse in the extended class was contacted,**
**iii. what other authorities were contacted about the incident, if any,**
**iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and**
**v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).**
**4. Analysis and follow-up action, including,**
**i. the immediate actions that have been taken to prevent recurrence, and**
**ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).**
**5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. In making a report to the Director under subsection 23 (2) of the Act, the licensee failed to include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of resident #001 by anyone or neglect of resident #001 by the licensee or staff that led to the report:

A description of the incident, the date and time of the incident and the events leading up to the incident;

A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident; and
iii. what other authorities were contacted about the incident, if any, iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident.

Review of MOHLTC's Critical Incident System (CIS) indicated that the home reported a Critical Incident on an identified date in May 2016, for an incident that was stated as having occurred on the same date in May 2016. The report stated "received complaint of poor care and we are investigating potential for abuse". An amendment was requested on the date the CI was submitted and not provided until two and a half months later in 2016.

Review of notes provided by the home indicated that in May 2016, the DOC reported to the home's Nurse Consultant that they submitted the CI but didn't include much information at this time. During interview, the DOC stated that the CIS was submitted regarding alleged, suspected, or witnessed abuse of resident #001 that had been confirmed during the home's investigation in 2016. The DOC also stated that they submitted the report as a Critical Incident rather than as a Mandatory report in error.

The home's investigation involved the review of evidence that demonstrated that resident #001 had received improper care and/or had been subjected to abuse between November 2015 and February 2016. During an interview in September 2016, the DOC confirmed that they were aware in April, 2016, of the incidents that occurred while staff provided care to resident #001 prior to reporting to the Director on an identified date in May 2016.

The DOC confirmed that material submitted in writing with respect to the alleged, suspected or witnessed incidents of abuse of resident #001 by anyone or neglect of a resident by the licensee or staff that led to the report was incomplete as follows:
i) The dates, times and events leading up to the known incidents of abuse and improper

care were not stated including the fact that there was four months of evidence that supported the allegations of abuse and improper care;
ii) The name of the resident was not provided when initially reported until two and a half months after the initial report;
iii) The known names of any staff members or other persons who were present at or discovered the incident were not reported until two and a half months after the initial report, when only PSW #128 was identified out of at least 15 staff;
iv) The names of other authorities that were contacted about the incident were not reported after police had been contacted;
v) Whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted was reported as "no" on the initial incident report even though the DOC confirmed during interview that they contacted the resident's family and met with them, at which time the family member provided further evidence that they felt demonstrated that staff had provided improper care and inflicted abuse upon the resident; the family member's name was not reported; and
vi) The outcome or current status of the individual or individuals who were involved in the incident was not reported on the initial report, or for two and a half months.

The DOC confirmed that material submitted in writing with respect to the alleged, suspected or witnessed incident of abuse toward resident #001 by anyone or neglect of a resident by the licensee or staff that led to a CIS being reported, according to Section 23(2) of the act, was not complete or according to legislative requirements. [s. 104. (1)]

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**Issued on this 24th day of February, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ROBIN MACKIE (511), HEATHER PRESTON (640), THERESA MCMILLAN (526) |
| **Inspection No. / No de l'inspection :** | 2016_250511_0011 |
| **Log No. / Registre no:** | 019456-16, 021976-16, 024225-16, 026676-16 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Aug 4, Nov 23, 2016 |
| **Licensee / Titulaire de permis :** | BELLA SENIOR CARE RESIDENCES INC.<br>1000 FINCH AVENUE WEST, SUITE901, TORONTO, ON, M3J-2V5 |
| **LTC Home / Foyer de SLD :** | BELLA SENIOR CARE RESIDENCES INC.<br>8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Dale Cowan |

To BELLA SENIOR CARE RESIDENCES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 901

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

**Order / Ordre :**

The home shall immediately notify the appropriate police force of the alleged abuse of resident #001, which the licensee suspect may constitute a criminal offence, on August 05, 2016, by 1200 hours.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

This Order is being issued based on the application of the factors of severity (3), scope (1) and Compliance history of (2) in keeping with s.299(1) of the regulation. This is in respect to the severity of actual harm or risk of harm that the identified resident experienced, the scope of one isolated incident and the home's history of non compliance.

In 2016, a Critical Incident report (CI) was submitted by the home to the Ministry of Health and Long Term Care (MOHLTC) that indicated that the home had received a complaint that alleged poor care and abuse of resident #001. The MOHLTC further received a complaint that alleged resident #001 had been abused. Interviews conducted by MOHLTC Inspectors in July, 2016, identified the following:
a. The Administrator, Director of Care (DOC), President of Assured Care Consulting Inc.(a member of the home's management company), the Nursing Consultant (NC) and the President/Director of Bella Senior Care Residence all confirmed they were aware of an alleged physical abuse of resident #001.

b. The DOC and President of Assured Care Consulting Inc., confirmed that the alleged abuse may have constituted a criminal offence.
c. The Administrator, Director of Care and the President of Assured Care Consulting Inc. confirmed that the police were not notified of the alleged abuse.
d. The home's policy, Investigation Process for Resident Abuse by Formal Caregiver, Volunteer or Visitor, section 4.1 Resident Rights and Safety, subsection 4.1.2, Abuse and Neglect Prevention, revised June 2015, directed the Administrator/Designate to notify the police immediately of any alleged, suspected or witnessed incident that the home suspected may have constituted a criminal offense.
e. The Administrator and DOC confirmed that the police should have been notified of the allegation of abuse of resident #001.

The Administrator, DOC and the President of Assured Care Consulting Inc. confirmed that the policy was not complied with when the licensee failed to notify the police for the alleged, suspected or witnessed incident that the home suspected may have constituted a criminal offense .

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constituted a criminal offence. [s. 98.] (511)

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to all residents as specified in their plans.

The plan is to include, but is not limited to the following:
1. Include an interdisciplinary process for care planning.
2. An auditing process to ensure that front line staff providing care are providing care as outlined in the plan of care.

The plan should be submitted via email by December 15, 2016 to Theresa McMillan at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

**Grounds / Motifs :**

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

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (4) in keeping with r. 299 of the Regulation. This is in respect to the severity of potential for actual harm that the identified resident experienced, the scope of pattern of incidents and the home's history of noncompliance that included the following: VPCs issued October 2016, May 2016, April 2016, February 2015; and Compliance Orders issued in May 2016, February 2015, and July 2014.

A) Continence care:
Review of resident #001's written plan of care, called the kardex, printed in

August 2015, and available to staff in a binder at the nurse's station, directed staff to toilet the resident at specific times. According to the kardex, staff were to check the resident during the night. Interview of PSW #123 in September 2016, confirmed they were to check the resident at specific times and change the resident as needed. PSW #123 confirmed that care during the night shift was not always completed as per the plan of care. In October 2016, the DOC confirmed that this was not done on the identified dates and it was the expectation that resident #001 would have had their continence product changed during the night shift.

A review of evidence, showed that on at least six occasions in November and December 2015, there was no continence care provided to resident #001. Resident #001 was not checked nor was their continence product changed during these observations.(640)

B) Peri care:
Resident #001's Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment, completed in October 2015, indicated that the resident had been incontinent. In January 2016, the RAI MDS, indicated the resident's continence condition worsened during the previous 14 day observation period. The written plan of care, available to staff, indicated that resident #001 wore an incontinence product for protection at all times and was at risk for skin breakdown. Staff were directed to provide peri care after each episode of incontinence and to monitor and report any areas of redness, irritation, or open areas.

Review of evidence indicated that peri care had not been provided by staff according to resident #001's plan of care on at least seven occasions in November and December of 2015.

During interview PSW #116 and the DOC confirmed that resident #001's peri care was not, and should have been, completed with each episode of incontinence according to the plan of care. (526)

C) According to resident #001's RAI MDS assessments completed in October 2015, and January 2016, they required assistance from two staff persons for bed mobility, dressing, personal hygiene and bathing.

A review of evidence indicated that on eight identified days in November and

December 2015, PSW staff #112, #104, #128, #112, and #118 had assisted resident #001 with bed mobility, dressing, hygiene and grooming and brief changes with one staff person rather than two persons as directed in the written plan of care.

During Inspector interviews, PSW #104, #112, #118, and #128, confirmed that the plan of care directed two staff to provide care to resident #001. They confirmed that they should not have provided care to the resident with only one staff. They confirmed that when they provided care alone, they had difficulty managing the resident's responsive behaviours and that they had become frustrated and angry with the resident. They confirmed that unsafe bed mobility and positioning techniques were used when dressing, washing, changing the brief and positioning the resident in bed when providing care alone.

When asked why they used one staff instead of two, three of the four PSWs interviewed reported that they were told by the registered staff to get the work done and were short staffed on a regular basis. During interview, the DOC confirmed that staff should not have provided care to resident #001 with only one staff person instead of two as per the plan of care. (526) [s. 6. (7)]

(526)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 16, 2017

**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. 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.

**Order / Ordre :**

The licensee shall:
1. Ensure staff follow the residents plans of care when assisting residents in relation to transferring, positioning, and turning techniques, according to their assessed needs and preferences.
2. Ensure all direct care staff receive retraining regarding safe transferring, positioning and turning techniques for assisting residents.
3. Ensure staff competency related to lifts and transfers be audited annually according to the home's policy, to ensure "the highest level of competency by the employees".
4. Ensure staff who do not pass the competency audit be paired with an employee who has passed their audit, re-educated, and retested.
5. Ensure documentation be retained of training, staff audit results, and retraining.
6. Establish an auditing process to ensure that staff using transferring and positioning devices or techniques to assist residents are using safe techniques appropriate to the needs of the resident.

**Grounds / Motifs :**

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

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (3) in keeping with r. 299 of the Regulations. This is in respect to the severity of potential for actual harm that the identified resident experienced, the scope of pattern of incidents and the home's history of noncompliance that included the following: Compliance Order issued in July 28, 2015.

According to resident #001's RAI MDS assessments in October 2015 and January 2016, they required assistance from two staff for bed mobility and transferring.

A) Transferring:
Review of evidence on 12 identified dates revealed staff used unsafe transferring techniques for resident #001.
On four specified dates in November 2015, six specified dates in December 2015, one specified date in January and one specified date in February 2016, evidence review and staff interview confirmed resident #001was transferred unsafely and at times causing the resident to grimace and appear to be in distress.

B) Turning and Positioning:
Review of evidence on seven identified dates revealed staff used unsafe positioning techniques while roughly turning and positioning resident #001 during care, while the resident was in bed.

During Inspector interview, the DOC confirmed that PSW staff had turned and positioned resident #001 in an unsafe and rough manner and had demonstrated unsafe transferring techniques as noted above. [s. 36.] (526)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 19, 2016

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

1. The Licensee shall protect all residents from abuse by anyone and keep them free from neglect by the licensee or staff in the home.

2. Take appropriate action in response to every such incident by doing the following:
a) Immediately investigate and document the investigation of every alleged, suspected or witnessed incident of abuse, neglect or anything else provided for in the regulations;
b) Prevent the risk of further abuse and neglect by immediately addressing suspected perpetrators of abuse in accordance with the home's policy;
c) Immediately report the suspicion of abuse to the Director according to s. 24(1);

3. Re-train all staff on the prevention of abuse and neglect in the home to include, at a minimum:
a) The home's "Abuse and Neglect Prevention" policy;
b) Definitions of abuse including verbal, emotional and physical abuse, and definition of neglect;
c) Practical examples of abuse and neglect for learning purposes;
d) Staff's responsibility if they witness or learn of an abuse or neglect against a resident;
e) Residents' Rights including the right to privacy and being treated with dignity and respect;
f) Communicating strategies to the resident during care;
g) Resistive behaviour/Gentle Persuasive Approach (GPA) training;
h) Continence management including using products according to the resident's assessed needs to ensure the resident's health, dignity and well-being;

i) Skin and wound management including peri-care,
j) Turning and positioning of residents according to their plan of care and when clinically indicated;
k) Transferring, turning and positioning safely and according to the resident's assessed needs;
l) Fluid and nutrition management according to resident's plan of care;
m) Infection prevention and control in the delivering of resident care;
n) End of life care;
o) Providing care with two staff as indicated in the resident's plan of care;
p) How to follow a resident's plan of care; and
q) PSW and RPN staff responsibilities when faced with challenges in providing care according to the plan of care.

4. Implement a process to ensure that all staff are following the home's "Abuse and Neglect Prevention" policy and all of the above stated re-training.

5. Evaluate the home's "Abuse and Neglect Prevention" policy according to legislative requirements.

6. Develop and implement recommendations to enhance the home's compliance with the "Abuse and Neglect Prevention" policy and legislative requirements in relation to the prevention of abuse and neglect.

**Grounds / Motifs :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone and were free from neglect by the licensee or staff in the home.

This Order is being issued based on the application of the factors of severity (3), scope (3) and Compliance history of (2) in keeping with r. 299 of the Regulation. This is in respect to the severity of actual harm or risk for actual harm that the identified resident experienced, the scope of a pattern that represented the number of staff involved and the home's history of noncompliance that included the following: Compliance Order issued July 28, 2015.

Resident #001's family member provided evidence to the home in April 2016, for an identified time period in 2015 and 2016. According to their health record, the resident had a cognitive impairment and required assistance from two staff for hygiene, grooming, continence and transferring.

A) Emotional Abuse: Review of evidence for an identified time period in 2015 and 2016, indicated that on at least 21 occasions, staff in the home exhibited emotional abuse toward resident #001 through threatening, insulting, intimidating and humiliating gestures, actions, behaviour or remarks, including shunning, ignoring, lack of acknowledgement and infantilization.

1. PSWs #104, #109, #111, #112, #113, #116, #117, #118, #119, #120, #121, #122, #124, #125, #128, #129, and #132 ignored and had not acknowledged the resident while providing care during this identified time. During interview, PSWs #104, #112, #116, #118, #120, #125, and PSW #128 confirmed that, according to the definition of abuse, ignoring and not acknowledging the resident was a form of emotional abuse.

2. PSWs #116 and #117 used profanities in reference to a resident while in their presence as provided in evidence on a identified date in November and December 2015. PSW #104 used a profanity when talking about personal matters to PSW #128, in the presence of a resident as provided in evidence on an identified date in November 2015. During interview, PSWs #104, #116, and #128 stated that these expressions were of an insulting and humiliating nature.

3. During interviews PSWs #118, #128 and #112 stated that during three identified dates they made remarks that were insulting and humiliating to the resident.

4. PSW staff #111, #118, #124, #128 were observed to be mimicking the resident by repeating their verbalizations, as provided in evidence, on identified dates in 2015 and 2016. During interview, the DOC confirmed that staff's mimicking of the resident was humiliating.

5. PSWs  #112, #117, #118, #128 exhibited gestures and actions that were threatening, insulting, intimidating or humiliating toward the resident on specified dates in November and December 2015.

On at least 20 occasions, PSWs were observed removing the resident's sheets/covers, quickly and forcefully without speaking to the resident. This resulted in the resident being startled and demonstrating a distressed expression.

During interviews, PSW staff #112, #118, and #128 and the DOC confirmed that

these gestures and the forcefulness of the actions were threatening, insulting, intimidating or humiliating to the resident.

6. PSW staff #117, #118, #124 and #128 yelled at the resident with an angry facial expression as reviewed in evidence on several identified dates in 2015 and 2016; PSW staff #118 and #128 confirmed that staff yelling at the resident was an intimidating remark.

7. PSW #118 yelled and made an identified degrading comment to the resident; PSW #118 confirmed that the remark made was degrading to the resident.

8. PSW #124 made gestures and remarks that were insulting and humiliating on two occasions in 2015; The DOC confirmed that these gestures and remarks were insulting and humiliating.

During interview, the DOC confirmed that resident #001 had been emotionally abused by PSW staff when PSWs demonstrated threatening, insulting, intimidating or humiliating gestures, actions or remarks, including ignoring, and lack of acknowledgement of the resident.

B) Physical Abuse: Review of evidence on an identified period in 2015 and 2016, indicated that on at least two occasions, staff in the home exhibited the use of physical force that caused physical injury or pain toward resident #001.

PSW #118 and DOC confirmed that actions taken were physically abusive toward resident #001 as the resident appeared to be in pain.

On an identified date in 2015 PSW #128 physically abused resident #001. The PSW continued to have an angry expression on their face, pushed the resident in their chair, walked away and yelled at the resident. During interview, the PSW stated that they were protecting themselves from the resident's responsive behaviour. They confirmed that the resident was in distress by their observed body movements, and attempts to speak and that this constituted abuse upon resident #001.

During interview, the DOC confirmed that PSW staff #118 and #128 had physically abused resident #001.

3. The evidence demonstrated that on at least seven occasions in November

2015, December 2015 and January 2016, at least five PSWs (#104, #112, #117, #118, and #128) were observed to use excessive force during the resident's care. During interviews PSW staff #104, #112, #118, and #128 stated that they physically held down the resident while providing care. The DOC confirmed that these actions were not appropriate and consisted of the use of excessive force during the resident's care.

C) Neglect: Review of evidence between November 2015, and February 2016, indicated that staff had neglected to provide the resident with the treatment, care, services or assistance required for health, safety or well-being and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of resident #001.

1) Staff did not give resident #001 their privacy in treatment and caring for their personal needs that was needed for the resident's well being.
Review of evidence provided between November 2015 and February 2016, indicated that PSW staff repeatedly failed to provide resident #001 with privacy during treatment and caring for his or her personal needs that was needed for the resident's well being. In particular, evidence for several identified dates in November 2015, December 2015 and January 2016,identified PSW staff #112, #117, #118, #128, and #130 not providing privacy in treatment.

PSW #112 confirmed that the resident appeared cold and frightened. PSW #128 confirmed that the resident should have been partially covered during care to provide them with their privacy. PSW staff #112 and #118 confirmed that the resident had attempted to cover themselves and had a distressed look on their face.

2) Staff failed to use safe transfer and positioning techniques when providing care and treatment to resident #001 as required for the resident's safety and well-being as set out in the resident's plan of care.
Staff neglected to transfer, turn and position resident #001 safely or according to their plan of care. According to resident #001's RAI MDS assessments in October 2015, and January 2016, they required assistance from two staff for bed mobility and transferring. The written plan of care, printed in August 2015, provided direction for care between November 2015 and February 2016 and directed staff to provide extensive assistance from two staff for bed mobility and transferring.

Transferring:
Review of evidence on several identified dates in November 2015, December 2015, January and February 2016, revealed PSWs #104, #109, #113, #116, #118, #124, #125, #128, #130, #132, #136, #137, #139, #140, failed to use safe transfer and positioning techniques when providing care and treatment to resident #001 as required for the resident's safety and well-being and as a result contributed to the resident's distress and risk for injury.

Turning and Positioning:
Review of evidence for identified dates, in November 2015 and December 2015, revealed that PSWs #104, #111, #112, #117, #127, #128, neglected to use safe positioning techniques while turning and positioning resident #001 during care. The resident demonstrated grimacing facial expression and an elevated tone of voice. PSWs #104, #112 and #128 confirmed this.

During interview, the DOC confirmed that PSW staff neglected resident #001 as they turned/positioned them unsafely and had demonstrated unsafe transferring techniques.

3) Staff only provided care by one staff and therefore, failed to provide care by two staff required for the resident's health, safety and well-being as set out in the resident's plan of care.
According to resident #001's RAI MDS assessments completed in October 2015 and January 2016, they required assistance from two staff persons for bed mobility, dressing, personal hygiene and bathing. The written plan of care printed in August 2015, for direction for care between November 2015 and February 2016, indicated that two staff were required when providing care to resident #001 for bed mobility, dressing, hygiene and grooming.

Review of evidence indicated that PSW staff #104, #112, #118, and #128 had assisted resident #001 with bed mobility, dressing, hygiene, grooming and brief changes with one staff person rather than two persons as directed in the written plan of care on several identified dates in November 2015, December 2015 and January 2016.

4) Staff did not implement strategies to manage responsive behaviours required for the resident's health, safety and well-being:
According to their health records, resident #001 had cognitive impairment and responsive behaviours. The resident's written plan of care provided staff with at

least 10 strategies to manage the resident's behaviours.

Review of evidence dated between November 2015 and February 2016, revealed that on at least 19 occasions, PSWs #104, #111, #112, #117, #118, #121, #124, #127, #128, and #132 had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours.

During interviews, PSW staff #104, #112, #116, #120, #125, and #128 confirmed that the resident had responsive behaviours. They confirmed they had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours. All PSWs confirmed that the resident appeared to be in distress through facial grimacing and tone of voice with an escalation of behaviours as they provided care while not implementing strategies to manage these behaviours.

During interview, the DOC confirmed that PSW staff had not implemented strategies developed to manage responsive behaviours. They confirmed that the strategies were required by the resident's health safety and well-being and staff not implementing the strategies contributed to the resident's distress and escalation of behaviours during their care.

5) Continence products used were not according to individual assessed needs and therefore, as required for the resident's health, safety and well-being.
Resident #001's RAI MDS assessments completed in October 2015 and January 2016, indicated that the resident was incontinent.

Review of evidence dated November 2015, December 2015 and January 2016, indicated that staff (PSWs #112, #116, #120, #124, #128 and #132) applied continence care products that were not based on the resident's assessed needs, did not properly fit the resident, and did not promote resident comfort, ease of use, dignity and good skin integrity.

Interview with PSWs #116, #120, #124, and #128, confirmed that staff often used non assessed products to manage resident #001's continence. PSW #112 stated that they thought that it was part of the plan of care, and PSW #116 stated that the resident could demonstrate responsive behaviours during continence care. According to staff interviewed, non-assessed products would diminish the number of brief changes required and was more convenient for staff. Staff stated that the strategies outlined had not promoted resident comfort,

ease of use, dignity and good skin integrity. The actions, as identified in the evidence, did not provide the resident with the treatment, care and assistance required for their health, safety and well being.

Interview with the DOC on September 30, 2016, confirmed that staff should have used the assessed continence products for resident #001. The DOC stated they could not verify that the strategies used by PSWs promoted resident comfort, ease of use, dignity and good skin integrity.

6) Staff had not checked for incontinence according to the resident's plan of care and therefore, as required for the resident's health, safety and well-being.
Review of resident #001's written plan of care, called the kardex, printed in August 2015 and available to staff directed staff to toilet the resident at specific times. Interview of PSW #123 on September 30, 2016, confirmed they were to check the resident for incontinence and change the resident as needed. PSW #123 confirmed this was not always done. On October 4, 2016 the DOC confirmed that this was not done on the dates identified and it was the expectation that resident #001 would have had their continence product changed at a minimum as specified in the plan of care.

A review of evidence, indicated that on at least six occasions, there was no continence care provided to resident #001. Resident #001 was not checked nor was their continence product changed on six identified dates for time period of five to ten hours.

7) Staff had not provided peri care according to plan of care and therefore, as required for the resident's health, safety and well-being.
Resident #001's RAI MDS assessments completed in October 2015, and January 2016, indicated that the resident was incontinent. The resident wore an incontinent product and the resident's plan of care indicated that the resident was at risk for altered skin integrity and directed staff to provide peri care with each episode of incontinence.

Review of evidence indicated that peri care had not been provided by PSW staff #104, #111, #116, #117, #119, #120, #123, #124, #127, and #128 according to resident #001's plan of care on at least six occasions on identified dates in November 2015 and December 2015. During interview PSW #116 and the DOC confirmed that resident #001 was at risk for skin breakdown and that peri care should have been completed with each episode of incontinence according to the

plan of care.

8) Staff had not turned and positioned resident #001 as clinically indicated and therefore, as required for the resident's health, safety and well-being.
Review of evidence on at least six occasions from November 2015 and December 2015, indicated resident #001 had not received any direct care for several hours during the night shifts. Resident #001 was not turned or repositioned by staff when they were dependent on staff for mobility. MDS assessment identified the resident to be dependent on two staff for mobility as documented in the written plan of care dated October 2015. Interview of PSW #123 confirmed resident #001 required two people for mobility and was not able to move about in bed independently. PSW #123 confirmed resident #001 should have been turned or repositioned and that this was not always carried out. DOC confirmed resident #001's condition was such that it was clinically indicated for this resident to be turned or repositioned as per their assessed care needs. (640)

9) Staff failed to provide resident #001 with adequate fluid consumption and failed to notify the RD regarding the resident's fluid intake, as required for the resident's health, safety and well-being.
Resident #001 was assessed by the Registered Dietitian (RD) and required a specific amount of daily fluid intake as documented in the written plan of care dated October 2015. When the resident had not met their fluid needs for the day, the Registered staff were to assess the resident for signs of dehydration and document results of the assessment in the resident record. If the resident's fluid intake was below their fluid needs for three consecutive days, the resident was to be placed on a fluid watch. The Registered staff were to have activated this task in Point Of Care (POC) to alert the staff to prompt extra fluids. A dietary referral was to be made to notify the (RD) that the fluid watch had commenced. A report run by RPN #102, from POC, indicated that on three consecutive days in 2015, resident #001 was below the assessed fluid needs for each day. There was no referral sent to the RD, no task activated in POC nor any documentation of the assessment for dehydration by a Registered staff. The DOC confirmed there was no referral, assessment or task assigned for resident #001 related to a three day decrease in fluid intake. The DOC confirmed it was the expectation that this should have been done and the home's Feeding and Hydration policy was not complied with. (640)

10) End of Life Care. Resident not reassessed when staff initially found the

resident had a change in their condition as required for the resident's health, safety and well-being.
An allegation from the resident's SDM indicated that resident #001 had not been assessed when they had a change in their condition on an identified date in February 2016 when two PSW's were observed to notice a change in the resident's condition.

A review of evidence, for an identified date in February 2016, revealed two PSW's going into resident #001's room. The two PSWs provided continence care to resident #001 and were heard to comment on the resident's health condition. Both PSWs stopped what they were doing, observed and commented on the resident's change in their health condition. The two PSW's then provided an intervention based on the observed resident's condition. The evidence indicated the resident was not observed again by the home's staff until nearly five and one half hours later. There was no documentation of an assessment or evidence of the resident being reassessed or monitored for their change in condition during the identified time period. The evidence further revealed two different PSWs had come into resident #001's room, the following shift, and identified the significant change in the residents condition and had notified a registered staff member. An RN arrived approximately five minutes later and the resident was assessed and documented as having a significant change in their condition.

A review of the clinical record indicated the resident was not reassessed or the plan of care updated when the two PSWs first noted a change in the resident's condition, as required for the resident's health, safety and well-being. Interview with the DOC confirmed the licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when resident #001's care needs changed. (511)

During interview on October 6, 2016, the DOC and Administrator confirmed that the licensee neglected resident #001 when staff failed to provide the treatment, care, services and assistance required for the resident's health, safety and well-being including the following:
1) Failed to fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs;
2) Failed to use safe transferring, lifting and positioning techniques;
3) Failed to follow the plan of care by providing care with one staff person instead of two as directed;

4) Failed to follow the plan of care that directed them in techniques and approaches in the management of resident #001's responsive behaviours;
5) Failed to use continence products according to resident #001's plan of care to promote comfort and dryness;
6) Failed to check the resident's incontinence product according to the resident's plan of care;
7) Failed to provide peri care for each episode of incontinence;
8) Failed to turn and reposition every two hours at night as clinically indicated;
9) Failed to ensure adequate fluid intake or to notify the RD;
10) Failed to provide end of life care according to the plan of care. (526)

D) Failure to protect residents from further abuse, improper care and/or neglect: According to their health records, resident #001 had cognitive impairment, exhibited responsive behaviours and required assistance with all aspects of their care. The resident's family member notified the home of abuse, improper care and/or neglect of resident #001 and then subsequently provided the home with evidence of alleged abuse between November 2015 and February 2016. According to the home's investigative notes, education files, human resources records, and interviews with staff in the home, the DOC, Administrator, Assured Care Consulting Inc. ("the Manager"), the Nurse Consultant, and the licensee, the licensee failed to protect all residents in the home from abuse, improper care and/or neglect after becoming aware of abuse, improper care and/or neglect upon resident #001.

1. Interviews confirmed that staff in the home became aware of suspected abuse, improper care and/or neglect upon resident #001 as follows:
i) Staff #103 before an identified date in March 2016;
ii) DOC in March 2016 by RN #103;
iii) Administrator in March 2016 by the DOC;
iv) Licensee during the first two weeks of April, 2016 by the DOC and Administrator;
v) Manager of Assured Care Consulting in May 2016 by the complainant;
vi) Nurse Consultant for Assured Care Consulting in May 2016, by the Manager.

2. The DOC confirmed that they investigated allegations of abuse, improper care and/or neglect in April 2016 by reviewing evidence and then stopped the investigation, took no action to protect other residents from abuse, improper care and/or neglect until the investigation started again in late May 2016. All PSWs identified as abusing and /or neglecting or providing improper care to resident

#001 continued to provide care to other residents during this time without being re-educated or held accountable for their conduct described in section A, B and C above and failure to comply with the home's policies for the prevention of abuse and neglect.

3. The DOC and Administrator confirmed that they did not immediately report to the Director, allegations of abuse, improper care and/or neglect, until approximately two months after they became aware of these allegations. The DOC also confirmed that this Critical Incident report had not included all known information according to legislative requirements.

4. The DOC and Administrator confirmed that they failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse, improper care and/or neglect of resident #001 that the licensee suspected may have constituted a criminal offense. The home was issued an immediate Compliance Order on August 4, 2016, to immediately notify the appropriate police force of the alleged abuse, improper care and/or neglect of resident #001, which the licensee suspected may constitute a criminal offense, and complied with this Order on August 4, 2016.

5. A total of 11 PSWs ( #104, #111, #116, #120, #124, #125, #127, #128, #129, #131, #132) in the home were disciplined related to the care and services they provided to resident #001.

6. During interview, the DOC confirmed the 21 PSWs, who had been working on the identified care area, that were identified in the evidence, continued to provide care to residents.

7. The DOC and ADOC confirmed that not all staff had received mandatory training in 2015 up to July, 2016 on the home's "Abuse and Neglect Prevention" policy. Mandatory training on approaches and strategies for residents with responsive behaviours was not provided to all staff in 2015 and for 2016 no staff in the home had received this education as of October 6, 2016. They confirmed that PSW staff had difficulty managing specified responsive behaviours and this may have contributed to their abuse, neglect and/or improper care. They also confirmed that all staff had not received annual training in 2015 up to July 2016, for safe transfers, skin and wound, and continence management.

The DOC confirmed that they did not act immediately to investigate, respond by

notifying and disciplining identified staff where determined necessary, report to the Director, notify police, or re-train staff in a timely manner to protect all residents in the home from abuse, neglect and/or improper care by staff identified in the evidence as having abused, neglected and/or provided improper care to resident #001. [s. 19. (1)] (526)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 30, 2017

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 004

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

**Order / Ordre :**

The licensee shall:
1. Comply with the home's Quality Management policies as per the "Bella Senior Care Residence Quality and Risk Management Manual" including, but not limited to, doing the following:
a) Monitor, analyze, evaluate and improve the quality of the accommodation, care services, programs and goods provided to residents according to legislative requirements;
b) Convene the home's "Quality Committee" at least quarterly as per the home's policy to fulfill its mandate;
c) Implement the Management Company's delegated responsibility and authority to the Administrator of the Home by receiving reports and providing feedback to the Administrator on issues and accomplishments related to quality improvement. The Management Company will direct, co-ordinate, and provide for ongoing development of the quality improvement philosophy and plan for the Home, according to the home's policy.

**Grounds / Motifs :**

1. The licensee failed to ensure that the home developed and implemented a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care services, programs and goods provided to residents.

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (2) in keeping with r. 299 of the Act. This is in respect to the severity of potential for actual harm, the scope of pattern of

incidents and the home's history of non-compliance that indicated noncompliance in unrelated areas in the past 36 months.

A) The home's "Bella Senior Care Residence Quality and Risk Management Manual", last reviewed September 2011, included policies regarding the home's quality management systems and processes.

The "Quality Process" policy number 1.2 indicated that the home was to:
i) "select and/or modify the indicators, audits or projects that fit with the significant aspects of the departmental operations using the dimensions of quality;
ii) Set up a routine data collection method for each critical indicator as a Quality Plan;
iii) Record the monitoring results and provide some analysis;
iv) Initiate problem solving activities when variations are flagged and subsequently identified as a pattern or trend in the data;
v) Evaluate each indicator to determine the usefulness of the indicator (at least once per year); and
vi) Report the results of monitoring activities in a statistical and descriptive format to staff, teams and the Board."

In addition, the policy directed the home to utilize a "Plan-Do-Study-Act" cycle of quality improvement that included identification of processes needing improvement, analysis of causes of the problem, generating solutions, development and implementation of a plan to improve quality.

Review of the home's audits completed in 2016, indicated that the home had an audit schedule that was partially followed. The DOC confirmed that not all audits for 2016 had been completed according to the home's schedule, and that no data were generated, no trends identified, no analysis completed, no processes identified for improvement, no causes identified, no recommendations, improvement plans, or actions had been taken to address quality deficiencies or make improvements regarding all programs in the home.

B) The "Quality Committee" policy number 3.1 indicated that a Quality Committee should meet quarterly or more frequently at the call of the Chair. The Administrator was the designated Chair of the committee. The purpose of the Quality Committee included providing visible direction, co-ordination and ongoing development of the quality management program, philosophy and

initiatives; and coordinating the review of quality indicators, trends, and issues occurring at the home.

During interview, the Administrator stated that they did not know when the Quality Committee had last met and did not know where to find the minutes of any Quality Committee meetings that had been held. The Administrator also stated they did not know if audits, data analysis, recommendations or implementation plans had been completed and suggested that the LTC Inspector ask the DOC for this information. The DOC confirmed that the home's Quality Committee had not met in 2015 and met once in 2016 in February/March.

C) The "Quality Committee" policy number 3.1 indicated that "The Management Company had delegated responsibility and authority to the Administrator of the Home. The Management Company receives reports and provides feedback to the Administrator on issues and accomplishments related to quality improvement. The Management Company directs, co-ordinates, and provides for ongoing development of the quality improvement philosophy and plan for the Home."

During interview on October 6, 2016, the Management Company's representative stated that they did not know when the last time the home's Quality Committee had met, and stated not knowing if or how the Quality Management Program was being implemented as of October 6, 2016 as required in the "Quality Committee" policy. [s. 84.] (526)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 17, 2017

**Order # / Ordre no :** 005

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

**Order / Ordre :**

The Licensee shall ensure there is a registered dietitian on site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties for the residents.
The Licensee shall:
1. Ensure a written contract is in place and available to the Licensee that defines the hours and days worked onsite by the RD.
2. Make available to the home's staff the RDs scheduled hours and days.
3. Ensure a written record is kept of the days and the hours worked in the home by the RD.

**Grounds / Motifs :**

1. The licensee failed to ensure that there was at least one registered dietitian for the home (2) who was a member of the staff of the home and was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

This Order is being issued based on the application of the factors of severity (2), scope (3) and Compliance history (2) in keeping with r. 299 of the Regulation. This is in respect to the severity of minimal harm or potential for actual harm, the scope of widespread affect and the home's history of previous unrelated non-compliance.

The LTC Inspector requested the Registered Dietitian (RD) hours from the home's Administrator. The Administrator stated they had no knowledge of: the RD's weekly schedule, the RD's legislated on site hours and the contents or whereabouts of the contract between the home and the service provider of the

RD. An interview with the Director of Care (DOC) revealed they had no knowledge of the RD's weekly schedule, the RD's legislated on site hours and the contents or whereabouts of the contract between the home and the service provider of the RD. The DOC provided the Inspector with paid invoices for the RD services for the months of August, September, November 2015 and April, May, June, and August 2016, which indicated a lump sum payment for monthly RD services paid to Marquise Hospitality with no differentiation of hours worked or rate of pay. The Administrator provided a copy of an email correspondence, received from the Regional Director of Operations in Ontario, for Marquise Hospitality Group, on a specific date in 2016. The email confirmed the RD was the registered, licensed dietitian at Bella Long Term Care Centre, was an employee of Marquise Hospitality and had been contracted to work at the site 80 hours per month. The RD was described to have worked every Thursday for 10 hours, on site and made up the remaining 10 hours per week on one to two other days during the week/weekend. The RD confirmed they were on salary in the amount noted. Interview of the Food Service Manager revealed no knowledge of required, legislated on site RD hours, neither the existence of a contract for the RD service nor the weekly schedule of the RD. Interview of the RD revealed they had no knowledge of required, legislated hours to be on site in the home, the existence of a contract for the RD service to the home and the belief that the agreement between the RD and the employer of the RD to be "casual as needed" at the home. The home's licensed bed capacity was 161 beds. For the month of May 2016, occupancy was 159 residents and the required on site RD hours were 79.5 hours/month. June 2016 was 158 residents and the required on site RD hours were 79 hours/month. July 2016 was 161 residents and the required on site RD hours were 80.5 hours/month. August 2016 was 158 residents and the required on site RD hours were 79 hours/month and September 2016 was 161 residents requiring on site RD hours to be 80.5 hours/month. The occupancy for each of the five months was confirmed by the Director of Care. The RD was unable to confirm actual hours worked but did identify being on site five dates in May 2016, six dates in June 2016, six dates in July 2016, seven dates in August 2016, and seven dates in September 2016. If the RD had worked 10 hours on each day identified as being onsite then the RD would have worked 50 hours in May, 60 hours in each of June and July, and 70 hours in each of August and September. The RD confirmed they had not worked more than 10 hours on any day for the five months noted. The RD confirmed the remaining required hours were made up by offsite documentation. The RD stated they were not on site at the home for the required time of 30 minutes per resident per month. [s. 74. (2)] (640)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 01, 2016

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 006

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee will ensure that all staff participate in the implementation of the Infection Prevention and Control program.

The Licensee shall do the following:
1. Retrain all direct care staff on hand hygiene and housekeeping practices that prevent cross contamination from soiled linens, garments and continence products in resident rooms,
2. Complete hand hygiene audits based on evidence-based practices,
3. Analyze, monitor and evaluate results of infection control audits,
4. Ensure the interdisciplinary team, that coordinates and implements the program, meets at least quarterly.

**Grounds / Motifs :**

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (3) in keeping with r. 299 of the Regulation. This is in respect to the severity of potential for minimal Harm/Risk or Potential for Actual Harm/Risk that the identified resident experienced, the scope of pattern and the home's history of on or more unrelated non-compliances in the previous 3 years.

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

A) During a review of the evidence it was identified that on several identified

days in November 2015, December 2015 and January 2016, several identified staff members had not participated in the implementation of the home's Infection Prevention and Control program when the staff had not followed or implemented measures or directions to prevent the transmission of infections.
Specified actions observed included:
i) Inconsistent use and changing of gloves during the provision of care.
ii) Lack of hand hygiene.
iii) On several occasions had thrown soiled briefs and unclean linens onto the resident's floor during the provision of care.

Interview with PSW #104 confirmed that "all" PSWs throw soiled briefs and linens on the floor during the provision care and pick it up off the floor at the end of the care. They stated this practice had not followed the home's Infection Prevention and Control program as soiled briefs were to be placed in the garbage and soiled linens directly in hampers. Interview with PSW #116 confirmed that inconsistent use of and changing of gloves, inconsistent washing of hands between points of care, were not supportive of hand hygiene that was part of the home's Infection Prevention and Control program.

A review of the home's internal documents on September 27, 2016, confirmed that eight PSW members ( #111, #116, #120, #125, #128, #129, #131, #132) had not followed the home's Infection Prevention and Control program. (511)

B) Review of evidence on several identified dates in November 2015, December 2015, and January 2016, indicated that PSWs #104, #115, #116, #117, #118, #124, #128, #129, and #132 and RN #122, had not participated in the implementation of the home's Infection Prevention and Control program during the provision of care of resident #001.

Actions included lack of hand hygiene during the provision of care, using bedding that had been placed on the floor and improper use of equipment.

Interview with the DOC confirmed the licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program during the provision of care for resident #001. (526) [s. 229. (4)] (511)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 01, 2017

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 007

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

**Order / Ordre :**

The Licensee shall:
1. Implement strategies that have been developed to respond to residents demonstrating responsive behaviours, where possible;
2. Assess and reassess residents with responsive behaviours in relation to the behaviours demonstrated
3. Document assessments, plan of care, and strategies implemented when responding to residents demonstrating responsive behaviours;
4. educate all staff on Responsive Behaviour Program and the care of residents with responsive behaviours;
5. Monitor that staffs implementation of strategies, to respond to residents, demonstrating responsive behaviours, is in accordance to the home's policy.
6. Implement an audit and evaluation process to ensure that the program is implemented and the needs of residents with responsive behaviours are addressed.

**Grounds / Motifs :**

1. The licensee has failed to ensure that b) strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible and c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (4) in keeping with r. 299 of the Regulation. This is in respect to the severity of potential for actual harm that the identified resident experienced, the scope of pattern of incidents and the home's history of noncompliance that included the following; VPC, May 2016, VPC, October 2015. The home was also issued a VPC for noncompliance with s.76 (7) 3 in October and May 20167 relating to failure to comply with annual training of all care staff for the management of responsive behaviours

According to resident #001's health records they were cognitively impaired and demonstrated responsive behaviours

(b) Strategies not implemented.
The written plan of care, printed in August 2015, and available to staff between November 2015, and February 2016, provided staff with ten descriptive strategies to implement when providing resident care to reduce the resident's responsive behaviours

Review of evidence between November 2015 and February 28, 2016, indicated that the resident demonstrated behaviours during approximately 40 care occasions and that PSWs #104, #111, #112, #117, #118, #121, #124, #127, #128, and #132 had not implemented the strategies that had been developed to manage behaviours.

During interviews, PSWs #104, #112, #116, #120, #125, and #128 confirmed that the resident had responsive behaviours. They confirmed they had not followed the resident's plan of care, or implemented strategies developed to manage responsive behaviours. During interview, RPN #135 stated that resident #001 would demonstrate responsive behaviour if care was not provided as directed in the plan of care. RPN #135 also stated that they observed PSWs #104, #121, #125 and #128 providing rushed care to resident #001 and without speaking with the resident and had instructed PSWs to re-approach if the resident was not happy.

PSWs #104, #112, #118, and #128 stated that they cared for the resident in a specified manner since they thought that the approach was expected of them in the course of providing care given the resident's responsive behaviours; they stated not knowing this was wrong. All PSWs confirmed that the resident appeared to be in distress through facial grimacing and tone of voice as they

provided care while not implementing strategies identified in the plan of care to manage these behaviours.

During interview, the DOC stated that PSW staff had not followed resident #001's plan of care, or implemented strategies developed to manage responsive behaviours. They confirmed that staff not implementing the strategies contributed to the resident's distress and escalation of behaviours during their care.

(c) Actions not taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The home's "Responsive Behaviour Management" policy Section 4.11.10, last reviewed June 2013, located in the Bella Senior Care Resident Services Manual, directed staff to do the following with residents that exhibited "Complex/Difficult/Responsive Behaviours":
i) Initiate behaviour documentation in the resident's record for a 7 day period,
ii) Hold interdisciplinary conference to be planned at the end of 7 day time period to review the behaviour tracking record,
iii) The Interdisciplinary team will analyze behaviours that occurred to identify triggers and consequence of the behaviour if possible,
iv) Continue to monitor behaviour and effect of interventions,
v) If behaviours continued, review with physician to obtain a consult for psychogeriatric assessment,
vi) Notify psychogeriatric team regarding the issue and provide a copy of the behaviour flow sheet, and
vii) Continue monitoring and documenting the resident's behaviours.

Review of resident #001's health record and interviews with PSWs #104, #112, #116, #118, #120, #125, and #128 revealed that the resident had cognitive impairment and demonstrated responsive behaviours. The DOC confirmed that the resident exhibited "Complex/difficult" behaviours according to the home's policy. The plan of care last revised in August 2015, directed staff to implement at least 10 different strategies for the management of their behaviours.

Review of resident #001's health record indicated that the most recent assessment by Behavioural Supports Ontario (BSO) had been in 2012. The DOC could not state when the last referral or completed assessment of resident

#001's behaviours had been. During interview, RPN #135 stated that BSO had not been involved with resident #001's care for at least two years. Review of the progress notes indicated no entries regarding responsive behaviours between November 1, 2014 and February 28, 2016. The DOC and ADOC confirmed that PSW staff should have notified registered staff of resident #001's behaviours and registered staff should have documented these issues in the progress notes. Notes written by the resident's physician between February 2015 and February 2016, indicated that the resident's behaviours had settled down and there were no new issues.

Review of the resident's health record did not reveal behaviour documentation such as the use of the Direct Observation Sheet (DOS) charting and the DOC was unable to confirm if or when it was completed last. Although the plan of care was updated in August 2015, the DOC confirmed that an interdisciplinary conference and/or behaviour team meeting were not held for management of resident #001's responsive behaviours according to the home's policy, that there was no evaluation or analysis to identify other strategies, and that staff had not documented the behaviours observed according to the home's policy.

During interview, PSWs #104, #112, #118, #125, and #128 stated that while they had not followed the plan of care, they had reported difficulties providing care and had been told by registered staff on numerous occasions to get the care done. In evidence provided by the resident's family member between November 2015 and February 2016, PSWs were observed providing care, without implementing identified intervention for responsive behaviours. The PSWs interviewed uniformly stated that they did not think that the care provided and the approach used was improper and stated that they continued to care for residents using the approaches that were identified as improper until they were educated in 2016.

The home failed to take actions, including assessments, reassessments and interventions, as described in their Responsive Behaviour program, into the plan of care for resident #001 to ensure that their care was based on their assessed needs and that the resident's responses to interventions were documented. [s. 53. (4) (b)] (526)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Jan 02, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 4th day of August, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Robin Mackie

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office