Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2017	2017_551526_0014	008331-17, 008332-17, 010137-17, 010138-17, 010139-17, 010141-17, 010142-17, 010143-17, 010144-17, 010145-17, 010146-17	Follow up

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

THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 25, 26, 27, and 31 2017; August 1, 2, 3, 8, 9, 10, 11, 14, 15, 16, 17, 21, 22, 23, 24, and 25, 2017.

The following intake inspections were completed during this follow up inspections

from Inspection Number 2017_587129_0002 (A1):
010137-17, CO #001, for s.6(7), plan of care;
010138-17, CO #002, for s. 6(10), plan of care;
010139-17, CO #003, for s. 20(1) compliance with prevention of abuse policy;
010141-17, CO #005, for s. 101(4) conditions of the license;
010142-17, CO #006, for O. Reg 79/10 s. 8(1)(b), compliance with policy;
010143-17, CO #007, for O. Reg 79/10 s. 36, lifts and transfers;
010144-17, CO #008, for O. Reg 79/10 s. 54, responsive behaviours;
010145-17, CO #009, for O. Reg 79/10 s. 53(4), responsive behaviours; and
010146-17, CO #010, for O. Reg 79/10 s. 131, medication management.

The following intakes from Inspection # 2017_569508_0004 were included in this follow up inspection report:
Intake #008331-17, CO #001, for O. Reg 79/10 s. 36, and
Intake #008332-17, CO #002 for O. Reg 79/10 s. 53(4).

Follow up inspections for intakes:
010140-17, CO #004, for s. 84, quality management; Inspection Number 2017_587129_0002 (A1), and
016125-17 for CO #001, for O. Reg 79/10, s. 8(1)(b), compliance with policy; Inspection Number 2017_555506_0012 are included in this inspection report.

The following inquiry was conducted: 020380-17 (allegation of abuse)

During the course of the inspection, the inspector(s) spoke with the Owner (Licensee), President of Assured Care Consulting (the Management Company), Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Consultant, Dietary Consultant, Office Manager, Nursing Department Assistant Manager, Nutrition Manager, Resident Assessment Instrument Co-ordinator (RAI), back-up RAI Co-ordinator, Resident Support Services Manager, Registered Dietitians, Physiotherapist, Physiotherapy Assistants, Recreation staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), restorative staff, Personal Care Providers (PCPs), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, reviewed clinical records, policies and procedures, audits, meeting minutes, annual evaluations, training

records, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
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.
- **10 WN(s)**
- **1 VPC(s)**
- **10 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
LTCHA, 2007 S.O. 2007, c.8 s. 101. (4)	CO #005	2017_587129_0002	129
O.Reg 79/10 s. 131. (2)	CO #010	2017_587129_0002	536
O.Reg 79/10 s. 36.	CO #002	2016_250511_0011	536
O.Reg 79/10 s. 36.	CO #001	2017_569508_0004	536
O.Reg 79/10 s. 36.	CO #007	2017_587129_0002	536
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_250511_0011	526
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_587129_0002	536

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

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

Specifically failed to comply with the following:

s. 6. (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 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A) Resident #003 had a health condition that affected their continence. The resident was reassessed and demonstrated a decline in their continence status. Review of their health records interviews with registered staff revealed that the plan of care to direct care interventions had not been reviewed or updated to address the resident's care needs that resulted from this change.

B) Resident #004 demonstrated a change in their level of continence and in the care required. Review of the plan of care and interviews with staff revealed that the plan of care had not been reviewed or updated to reflect this change, or interventions identified to assist resident #004 with their current continence needs. [s. 6. (10) (b)]

2. 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 c) care set out in the plan had not been effective.

The Director of Care (DOC), registered staff #111 and resident #021's clinical record confirmed that the plan of care had not been reviewed or revised when it was identified that the interventions in place related to falls had not been effective. The care interventions identified in resident #021's plan of care had not been effective in attaining the identified goals of care, the resident continued to fall and the resident's plan of care had not been reviewed or revised despite the care being provided to the resident to manage falls not being effective. [s. 6. (10) (c)]

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.

WN #2: 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 failed to ensure that residents were protected from abuse by anyone and were free from neglect by the licensee or staff.

Review of progress notes and interviews with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN) #124 and recreation staff #215 revealed that, on a specified day in 2017, resident #009 became physically responsive toward resident #001. Recreation staff #215 intervened, informed registered staff who assessed the resident and documented an injury that they observed on resident #001 that appeared to occur during the altercation. In addition, RPN #124 reported that resident #001 expressed being upset following the incident.

RPNs #124 and #111 and RN #106 stated that these two residents demonstrated responsive behaviours under certain circumstances and it was these circumstances that triggered the incident. Review of resident #001's plan of care revealed that it did not address the risk for altercations and/or resident to resident abuse that resident #001's behaviour might have triggered, especially when it was known that the behaviour may directly trigger #009's responsive behaviours. During interview, Registered Nurse #101 confirmed that the altercation between residents #001 and #009 resulted in physical abuse to resident #001.

During interview, the Director of Care (DOC) confirmed that a risk for altercations existed between residents #001 and #009, interventions were not in place to fully address this risk, resident #001 had been injured during an altercation with resident #009, that this constituted physical abuse and that staff failed to protect residents from abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 002 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.

WN #3: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero

tolerance of abuse and neglect of residents and that it was complied with.

Review of the home's Resident Rights and Safety "Abuse and Neglect Prevention" policy number 4.1.2 last reviewed May 2017, directed staff to do the following:

"Any 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 their Supervisor, the Director of Care or the Administrator:...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" and "All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator". And

“The following persons are guilty of an offence under the Long Term Care Homes Act if they fail to make a report required by legislation:
1. The Home or a Management Company
2. If the Home is licensed or managed by a corporation; the Corporation, an officer or the director of the corporation
3. Any staff member
4. Any person who provides professional services to a resident in the areas of health, social work or social services work”.

Review of progress notes and interviews with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN) #124 and recreation staff #215 revealed that, on a specified day in 2017, there was an altercation between two residents that resulted in injury to one of the residents. In addition, RPN #124 reported that the injured resident expressed being upset following the incident. During interview, RPN #124, RN #106, the Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed that the resident suffered abuse when they were injured as the result of an altercation with resident #009.

Review of the Critical Incident System revealed that a report was made approximately 26 hours after the incident had occurred. During interview, RPN #124 stated that they reported the incident to Registered Nurses #101 and #106 after the incident had occurred. RN #101, who was working in the home at the time of the incident stated that they were told about the incident by RPN #124 and that the resident was doing fine; they did not assess resident #001 and did not think they were injured.

RN #101 stated that they reviewed progress notes that indicated that the resident had sustained an injury, they did not think the incident was serious and gave report to the oncoming RN #106. They stated that they did not view the incident as abuse since the altercation was not intentional and resulted from one resident responding to another resident's behaviours. They stated that they did not immediately report the incident to the Director or to the DOC or ADOC, or to the Director, according to the home's policy.

RN #106 stated that they had not reported the incident to the ADOC/DOC since the incident had not occurred on their shift, that the other RN would have contacted them, and they thought the resident had not been injured. The ADOC stated that they learned of the incident when reading the 24 hour report of progress notes the following morning. The ADOC and DOC confirmed that the mandatory report to the Director of physical abuse of resident #001 had not been reported immediately according to the home's policy and legislative requirements.

2. The licensee has failed to ensure that staff complied with the licensee's policy "Abuse and Neglect Prevention" identified as section: 4.1, subsection 4.12, last reviewed in May 2017.

This policy directed "All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care [DOC] or the Administrator".

On a specified day in 2017, Personal Care Provider (PCP) #214 called the Director of Care (DOC) and advised them that approximately 14 days earlier, they were a witness to an incident of verbal abuse by staff #191 toward an identified resident. Following the home's investigation, verbal abuse could not be verified. However, the DOC confirmed that PCP #214 was disciplined for failure to report the alleged incident of verbal abuse according to the home's policy. The DOC confirmed that the licensee failed to ensure that staff complied with the home's policy on abuse.

3. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Review of the home's Resident Rights and Safety policy "Abuse and Neglect Prevention"

identified as section 4.1, subsection 4.1.2 and last reviewed in May 2015, directed staff as follows:

"Any 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 their Supervisor, the Director of Care or the Administrator:...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";

"All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator";

"The following persons are guilty of an offense under the Long Term Care Homes Act if the fail to make a report required by legislation:
1. The Home or a Management Company
2. If the Home is licensed or managed by a corporation; the Corporation, an officer or the director of
the corporation
3. Any staff member
4. Any person who provides professional services to a resident in the areas of health, social work or
social services work"; and

"The Administrator/Designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System, or via pager (after hours or holidays)".

During interview, Registered Nurse #101 stated that they used to call the Director via the after hours phone, but recently, had been instructed to inform the DOC or ADOC about suspected or actual abuse and not initiate reports themselves. They said that they were somewhat confused about their duty to report suspected or actual abuse to the Director.

During interview, the Nurse Consultant confirmed that they revised the home's "Abuse and Neglect Prevention" policy in May 2017. During interview, the Director of Care (DOC), and the Assistant DOC (ADOC) were questioned about the home's policy that contained an explanation of the duty under section 24 of the Act to make mandatory reports, to direct any person who had reasonable grounds to suspect that any of items

listed in section 24(1) of the Act had occurred or may occur, to immediately report the suspicion and the information upon which it was based to the Director. The DOC stated that previously, the policy directed all staff to report suspected or actual abuse to the Director and this resulted in reporting of incidents that did not fit the legislative definition of abuse. The policy was changed to reflect a process in the home that required staff to report to registered staff, who would then report to the DOC or ADOC, who would then report to the Director. They confirmed that the "Abuse and Neglect Prevention" policy did not fully comply with section 24 of the Act that any person had a duty to immediately report the suspicion and the information upon which it was based to the Director. [s. 20. (2)]

Additional Required Actions:

CO # - 003 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.

WN #4: 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 implement 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 of the long-term care home.

Directions for implementation of the licensee's quality improvement and utilization review system were identified in the following documents located in the Bella Senior Care Residence Quality and Risk Management Policies and Procedures Manual:
"Quality Process", identified as section 1.0, subsection 1.2 and last reviewed in September 2011;
"Organizational Chart", identified as section 2.0, subsection 2.1 and last reviewed April

2017;
"Quality Committee", identified as section 3.0, subsection 3.1 and last reviewed/revised in August 2017;
"Quality Indicators", identified as section 4.0, subsection 4.1 and last reviewed/revised August 2017;
"Quality Audits", identified as section 5.0, subsection 5.1 and last reviewed/revised August 2017;
"Quality Projects", identified as section 6.0, subsection 6.1 and last reviewed September 2011;
"Benchmarking", identified as section 7.0, subsection 7.1 and last reviewed September 2011;
"Risk Management", identified as section 8.0, subsection 8.1 and last reviewed September 2017;
"Lockout and Tag out of equipment", identified as section 8.0, subsection 8.2 and created March 2013; and the following audit templates: 17 Administrative, 28 Nursing, 11 Nutrition Services, and 5 Infection Control.

A) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Process".

i) The "Quality Process" policy identified a quality improvement process that included: selection and/or modification of indicators, audits or projects; set up routine data collection methods for each critical indicator as a Quality Plan; record the monitoring results and provide some analysis; initiate problem solving activities when variations are flagged and subsequently identified as a pattern or trend in the data; evaluate each indicator to determine the usefulness of the indicator and report the results of monitoring activities in a statistical and descriptive format to staff, teams and the Board.

The Administrator stated that they realized the seriousness of the home's legislative non-compliance in relation to the home's quality improvement and utilization review system only after Inspection number 2017_587129_0002 that was served on May 11, 2017. It was at approximately that time that steps were taken to address the deficiencies in the home's quality improvement and utilization review system that had been identified during that inspection. According to the home's Director of Care (DOC), Assistant DOC and Nurse Consultant, implementation of the home's Quality Process policy was in the beginning stages.

As of the time of this inspection, the DOC reported that there had been four Quality Council meetings beginning May 3, 2017, during which time Council members stated that they did not know what quality indicators were and that they were not conducting quality audits. Since that time, the Council had developed a proposed terms of reference, had received education about the home's quality improvement and utilization review system including quality indicators and audits, and they began to select relevant quality indicators for the purposes of auditing. During the August 1, 2017 meeting, the Performance Indicator History Summary generated from PCC (June 2017) was reviewed and preliminary improvement strategies discussed. The DOC stated that these data had not been analyzed but would be formally analyzed at the end of the current quarter.

ii) The home's "Quality Process" policy included the "Improvement Plan Process" that directed staff to work in a team according to the needs of the organization, to define a problem, analyze the problem's cause, generate solutions and develop an improvement plan. Implementation of the quality process was not interdisciplinary as follows:

-The Nurse Consultant who was contracted to oversee the home's quality improvement and utilization review system described their actions and they included the review of care plans to make update recommendations. They stated that the information was gathered independently, and was communicated via email to the DOC and verbally to the DOC and staff; however, emails were not provided. While, the reviews were provided to Long Term Care Homes (LTC) Inspectors; a summary quality analysis of the care plan review and recommendations were not provided.

-Programme evaluations for Wound and Skin Care, Continence Improvement, and Falls Prevention and Restraint Reduction for data ending April 2017, and for Responsive Behaviour Management for data ending June, 2017, were provided to the LTC inspectors. According to interviews with the Nurse Consultant and the DOC, these evaluations were completed independently by the Nurse Consultant on June 19, 2017, and not by an interdisciplinary team/Quality Team or DOC/ADOC to review, analyze or develop strategies according to the home's quality improvement and utilization review system.

iii) The plan for corrective action developed by the home and submitted to the Ministry in response to inspection 2017_587129_0002 following a compliance order served to the home on May 11, 2017, related to continuous quality improvement, indicated: "d) Quality Indicators identified by Quality Council with Quality Leads inputting quality data into PCC QIA module";" e) Quality Council to review Quality Indicators to identify trends in data

and develop an action plan to improve quality services and programs for residents"; and "3. Administrator to submit quality report to Owner and ACC (Assured Care Consulting) monthly outlining all meetings, and data from quality improvement teams".

Review of documents provided by the home and interviews with the Owner, ACC President, Nurse Consultant, Administrator, DOC and ADOC revealed that all quality indicators had not been developed, audited, reviewed, or analyzed for recommendations and strategies. In addition, quality reports outlining all meetings, and data from quality improvement teams were not submitted to the Owner and ACC. No reports as indicated in the plan of correction were developed or provided to LTC Inspectors upon request.

B) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Committee".

i) The preamble of the "Quality Committee" policy set out a structure to be implemented to ensure the governance responsibilities for quality improvement were fulfilled. The structure identified that the governing body (licensee) had the ultimate responsibility for the quality of care and services and the management of risk. The licensee delegated quality management oversight to the Management Company. During interview the licensee stated that they had general conversations and exchanged emails about the home with the Management Company. They spent time in the home interacting with staff and residents however they stated that they trusted the administrative team and Management Company to manage quality in the home. They were not provided quality reports by the Management Company and could not provide examples or documentation regarding any quality issues.

-The Management Company was staffed by the President of the company, and they attended the home approximately weekly. They had hired an interim Administrator, Nurse Consultant, and Dietary Consultant to operate the home. Meetings and/or conversations between these people and with the licensee were not documented. The Management Company President stated that the Nurse Consultant was their delegate for all quality issues in the home, that their own expertise was not health related and that they felt unable to speak to the quality of care of residents in the home. The President of the Management Company stated that they monitored the following quality indicators: complaints from families and residents, labour issues, and physical plant of the building. They stated that the quality of the Nurse Consultant's management of the quality improvement and utilization review system was not assessed or evaluated.

- According to the Management Company President and the Nurse Consultant, the Nurse Consultant was hired by the Management Company to oversee the home's quality improvement and utilization review system. The Nurse Consultant confirmed they had not provided quality reports to the Management Company, the Administrator or the Licensee. According to the Nurse Consultant, they delegated the implementation of care related aspects of the quality improvement and utilization review system and addressing legislative non-compliance to the Director of Care (DOC). They implemented a review of resident plans of care, updated policies and produced annual programme reviews. They confirmed that they attended two out of four (2/4) quality meetings. They provided documentation regarding their review of the plans of care of every resident in the home, but did not include an analysis of this review or home wide strategies to address plan of care deficiencies.

ii) The Preamble of the "Quality Committee" policy indicated that the Management Company delegated responsibility and authority for the quality improvement and utilization review system to the Administrator. The Management Company was to delegate day to day operational responsibility to the Administrator, who, with the support of the Quality Committee and senior leadership was to submit quarterly reports to the Manager on quality improvement initiatives and activities for managing risk. The responsibility and authority for executing the components of the quality system and procedures were to be delegated to the Quality Care Teams.

The Administrator had been hired by the Management Company since December 2016. The Administrator stated that they delegated care related aspects of the quality improvement and utilization review system to the DOC including the monitoring of Quality Care Teams' activities. They said that they only focused on non-care issues such as Laundry, Housekeeping, Maintenance, and labour relations issues. The Administrator could not comment on specific aspects of the home's quality improvement and utilization review system in relation to care of residents. They confirmed that they had not submitted quarterly reports to the Management Company on quality improvement initiatives and activities for managing risk. They did not normally attend Quality Council meetings.

iii) The Preamble of the "Quality Committee" policy indicated that the Management Company was to receive reports and provide feedback to the Administrator on issues and accomplishments related to quality improvement. During interviews, the Management Company President, Nurse Consultant, Administrator, and DOC confirmed that verbal reports and feedback were exchanged on an ongoing basis. However, these

conversations were not documented to demonstrate the implementation of the home's policy. No written reports were provided to the Management Company, and the Administrator and President of the Management Company could not provide documentation that indicated their familiarity with the home's quality improvement and utilization review system.

iv) The Preamble of the "Quality Committee" policy indicated that the Management Company was to direct, co-ordinate, and provide for ongoing development of the quality improvement philosophy and plan for the home. The Nurse Consultant was delegated to fulfill this Management Company function. However, interviews and review of documents provided by the home, revealed that the ongoing development of the quality improvement activities in the home was not coordinated between all staff involved as follows:

- The Management Company President and Administrator could not speak to specifics of the home's quality improvement and utilization review system. They described the home's current approach to the home's quality improvement and utilization review system as "hands on" and reactive to legislative non-compliance and resident/family complaints.

- The Nurse Consultant who was the Management Company's quality management delegate failed to attend two out of four Quality Council meetings held between May and August 2017 stating that they were not working in the home on the days of the meetings.

- The Nurse Consultant produced programme evaluations for the wound and skin care, responsive behaviours, continence improvement, and falls prevention programmes that demonstrated a lack of interdisciplinary coordination with the DOC, ADOC, and respective Quality Teams.

- The Nurse Consultant produced a "Quality Score Card" on August 31, 2017, dated June 2017, that was not provided by the home during the onsite follow up inspection for compliance order #004 in relation to LTCHA, 2007, s. 84, conducted between July 25 and August 25, 2017. During this time, the President of the Management Company, the Administrator, the Nurse Consultant and DOC were asked for any and all documents related to the home's quality improvement and utilization review system and this document was not provided until after the inspection team had completed the onsite inspection.

- The Nurse Consultant reviewed and revised the home's Safe Handling and Assessing

Residents , Bowel and Bladder Management, and Responsive Behaviour Management policies without collaboration with the DOC or respective Quality Teams.

- The Nurse Consultant reviewed the home's "Abuse and Neglect Prevention Program" policy after which time the policy did not meet legislative requirements under section 20(2) in the Act;

- A consulting dietitian reviewed and revised the Nutrition and Hydration policies that were approved by the Management Company President and implemented in March 2017. This was conducted without the knowledge or collaboration with the DOC or Registered Dietitians who were staff in the home. The policies were pulled out of circulation by the DOC in July 2017 when they learned that they had been updated and implemented without their knowledge, since directions in the policies conflicted with current nursing practice.

- The DOC and ADOC modified the home’s Hydration Program policy without collaboration with the Nurse Consultant, or Registered Dietitians who were staff in the home.

v) The Procedure for the “Quality Committee” policy indicated that the Administrator shall: “a) chair the Quality Committee as available, b) schedule meetings quarterly or more frequently at the call of the Chair, c) be responsible for scheduling meetings, formulating the agenda and conducting the meeting, d) support the establishment of Quality Project Teams and confirm the selection of a Coach to support the team, e) review regular update from the project team on the progress of the quality activities, f) coordinate regular communications to the Management Company and Owner, and g) ensure appropriate rewards and recognition for successful improvement activities.” During interview, the DOC and Administrator confirmed that the Administrator had not been complying with items a) through e), regarding their role in the “Quality Committee” policy. The DOC stated that when these functions were not implemented by the Administrator, they took them on to ensure that the work was completed.

At the time of this inspection the licensee had not ensured that the structure identified in the “Quality Committee” policy had been implemented.

C) The Licensee, the Management Company and the Administrator failed to implement the licensee’s quality improvement and utilization review system when they failed to comply with directions contained in the licensee’s policy “Quality Indicators”, identified as

section 4.0, subsection 4.1 and last reviewed/revised August 2017. Review of the home's "Quality Indicators" policy directed staff to track defined indicators quarterly or monthly as specified from the home's Point Click Care Quality Improvement Administrator program. During interviews, the DOC and Nurse Consultant indicated that the program can produce reports on selected indicators, however they confirmed that Quality Teams and program managers were in the process of determining which quality indicators would be most helpful to routinely collect. The Quality Council and Quality Care Teams had not conducted quarterly analysis of all indicators as of this inspection.

D) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Audits", identified as section 5.0, subsection 5.1 and last reviewed/revised August 2017. Review of the home's "Quality Audits" outlined the standard routine annual and quarterly audits that should be conducted in the home for the following systems: Administration, Nursing Services, Documentation, Infection Control, Recreation and Leisure, Volunteer Services, Dietary, Environmental, Accounting, Human Resources, Occupational Health and Safety, and Pharmacy and Medication Services. During interview, the DOC and Nurse Consultant indicated that members of the Quality Council were in the process of determining what indicators they wanted to audit to inform the extent to which all systems in the home were effective and efficient. Documentation was provided for the following audits currently being conducted in the home:

• Personal Care Provider (PCP) Focused Audits that contained monitoring of PCP responsibilities;
• Nursing Department Safety Audits;
• Room Audits;
• Monthly care plan audits: one for each resident monthly on a schedule
• Recreations audits;
• Fridge, Freezer and Food temperature audits;
• Room and building temperature audits;
• Water temperature audits;
• Monthly safety inspection checklists;

During interview, the DOC and Nurse Consultant confirmed that while audits were completed for Medication Management and Falls Prevention, the home had not been conducting all audits according to the home's policy. In addition, The DOC confirmed that the data gathered in these audits had not been analyzed for trends, recommendations

created, or strategies implemented.

E) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policies as follows:
i) "Quality Projects" identified as section 6.0, subsection 6.1 and last reviewed/revised September 2011;
ii) "Benchmarking" identified as section 7.0, subsection 7.1 and last reviewed/revised September 2011; and
iii) "Risk Management" identified as section 8.0, subsection 8.1 and last reviewed/revised September 2011.

During interviews, the DOC and Nurse Consultant confirmed that these policies had not been reviewed or revised in 2017. The Nurse Consultant and President of the Management Company indicated that the home had submitted Quality Improvement Plans (QIP) to the Local Health Integration Network as required. However, the Nurse Consultant and DOC confirmed that the home had not complied with the "Quality Projects", "Benchmarking", or "Risk Management" policies as part of the home's quality improvement and utilization review system.

During interviews, the President of the Management Company, the Administrator, the Nurse Consultant, the DOC and ADOC indicated that the home's quality improvement and utilization review system that monitored, analyzes, evaluated and improved the quality of the accommodation, care services, programs and goods provided to residents was in a developmental phase and confirmed the system had not been fully implemented. [s. 84.]

Additional Required Actions:

CO # - 004 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.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Review of health records revealed that resident #001 and #009 were identified as having responsive behaviours that increased the risk for altercations and potentially harmful interactions between residents. Resident #001's health record revealed that suggested interventions to prevent altercations were not routinely implemented or documented. Interventions to prevent resident #009's behaviours that may lead to altercations were known to not be effective. RPN #111 stated that resident #001 and #009's behaviours could trigger responsive behaviours and potentially harmful interactions between residents.

Review of progress notes and interviews with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN) #124 and recreation staff #215 revealed that, on a specified day in 2017, there was an altercation between two residents that resulted in injury to one of the residents. In addition, RPN #124 reported that the injured resident expressed being upset following the incident. During interview, RPN #124, RN #106, the Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed that the resident suffered abuse when they were injured as the result of an altercation with resident #009.

Resident #001's health records revealed that they had not been reassessed until almost

one month after the incident to confirm that their behaviours could trigger altercations and that this was potentially harmful to residents, particularly between them and resident #009. During interview, RPN #111 stated that many residents on the home area exhibited similar behaviours and a normal occurrence. RN #101 and the Nurse Consultant both indicated that these behaviours were a normal part of dementia and should not cause harm to other residents.

Health records and interviews with RPN #124 and #111 confirmed that prior to the incident between resident's #001 and #009, resident #001's plan of care did not include strategies to prevent altercations between the two residents. They stated that they had not thought to reassess resident #001's behaviours or to update their plan of care and that, after discussing it with the Long Term Care Home's inspector, they recognized that resident #001's behaviours triggered an altercation between the two residents. The Director of Care (DOC) confirmed that resident #001 had not been reassessed or their plan of care updated to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 007 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration programs included the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who was a member of the staff.

Review of the home's "Feeding and Hydration - Hydration Program" number 4.9.1, reviewed and revised July 2017, outlined the following direction regarding monitoring and evaluating fluid intake of residents:

"If the resident's fluid intake is below their fluid needs for three consecutive days, the resident will be placed on Fluid Watch" and

"Residents who do not consume 1000 ml for 3 consecutive days will be placed on Fluid Watch: the Registered Staff will activate the Fluid Watch task in POC to alert nursing staff of the need for increased fluids, promoting extra fluids to be offered throughout the day. A Dietary Referral is to be sent to the FSM/RD to communicate that the Fluid Watch has been stated and the FSM/RD will update the care plan."

A) Review of resident health records revealed that residents #045, #007, #046, and #033 were on fluid watch and were referred for Registered Dietitian consultation by Registered Nurse (RN) #103, in relation to their fluid and hydration needs.

During interview, RN #103 said the home's process for placing a resident on fluid watch and RD referral required that they review a report that was generated during the previous night shift. The report identified which residents fell below their fluid need requirements so that a RD referral could be initiated by the RN working during the day shift. A notation on the report indicated that a RD referral should be made only if residents' fluid intake fell below 1000 ml for three consecutive days. The RN stated that they were not aware of this new policy until the RD spoke with them on the day of the interview. They confirmed that their process and practice had been different than what was written in the home's "Feeding and Hydration - Hydration Program" policy.

During interview on August 22, 2017, the home's two Registered Dietitians (RD) stated that they had not been consulted and had not seen this policy until the day of this interview. They confirmed that the policy was confusing since the staff were directed to initiate a fluid watch both when a resident's fluid intake was less than their daily need for three consecutive days, and also when the fluid intake was less than 1000 ml for three consecutive days. They stated that there should have been revisions that would include more clarity about when a fluid watch should be initiated and that staff should be directed to refer to a resident's plan of care for an individualized minimum fluid intake amount that should trigger initiation of a fluid watch and referral to a RD. They also stated that the automatic trigger that alerted registered staff about low fluid intakes had not been reset to 1000 ml and so continued to prompt a RD referral based on the home's previous policy. The two RDs in the home stated that staff had not complied with the home's Hydration Program policy when they initiated a RD referral when a resident's fluid intake was not less than 1000 ml, or according to their plan of care, for three consecutive days.

B) During interview, the external Consulting Dietitian indicated that they had reviewed the policy but had not consulted the RDs in the home. The Director of Care (DOC) stated that they had reviewed the Hydration Program policy and directed the Assistant DOC to revise it to reflect that RD referrals should only be made when a resident's fluid intake fell below 1000 ml for three consecutive days; before the policy could be reviewed by the RDs who were staff in the home, all staff in the home were educated on the policy and the policy was implemented.

The DOC also stated that during March 2017, the home's Feeding and Hydration policies were updated by a consulting RD without input from the RDs who were members of the staff in the home, then approved by the home's Management Company and provided to the Food Services Manager for implementation. The DOC confirmed that the home had failed to comply with legislative requirement that nutrition care and hydration policies be developed and implemented in consultation with RDs who were staff in the home. [s. 68. (2) (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #003 had a health condition that affected their continence. Review of their health records interviews with registered staff revealed that the plan of care to direct care interventions had not been reviewed or updated to address this change.

During interview, the RAI Coordinator indicated that the resident's change in continence would have warranted a continence assessment using the clinically appropriate instrument that was designed for assessment of incontinence and that was found in the assessment tab of the home's electronic documentation system. Review of the assessment tab revealed that no continence assessment had been completed. [s. 51. (2) (a)]

Additional Required Actions:

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

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

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 written approaches to care were developed to meet the needs of the residents with responsive behaviours that included screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

On July 25, 2017, Long Term Care Homes (LTC) Inspectors requested that the home provide policies that directed staff regarding care provided to residents with responsive behaviours. The home provided one policy as follows: The Residents with Special Needs "Responsive Behaviour Management" policy number 4.11.10, last reviewed May 2017. This policy directed staff about their role in the care of residents with "severe escalating" high risk responsive behaviours, such as residents who posed a significant risk to

themselves, other residents, staff and /or visitors. The policy did not include written approaches to care for residents demonstrating other behaviours such as resistance to care, wandering, agitation, anxiety, in relation to screening protocols, assessments or reassessments and identification of behavioural triggers. This inspection revealed that residents #027, #028, and #029 had not been assessed or reassessed when they exhibited responsive behaviours that were not "severe escalating" high risk responsive behaviours according to Registered Nurse (RN) #101.

During interview, the Director of Care (DOC), Assistant DOC, and RN #101 who was the responsive behaviour lead in the home, reported that the Clinical Consultant hired by the licensee's delegated Management Company discarded many of the home's previous responsive behaviour policies. The Nurse Consultant confirmed that staff had access only to the above mentioned policy regarding "severe escalating" behaviours. The policy was reviewed with the Nurse Consultant, the DOC, ADOC and RN #101; they confirmed that the policy did not include written approaches to care that included screening protocols, assessment, reassessment or the identification for behavioural triggers that may result in responsive behaviours. [s. 53. (1) 1.]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours that behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to the behaviours, where possible and actions were taken to respond to the needs of the resident, including assessments and reassessments.

During interviews, Registered Practical Nurses (RPNs) #112, #113, and #123, Registered Nurse #101 who was the Responsive Behaviour lead in the home, the Director of Care (DOC) and Assistant DOC stated that residents demonstrating responsive behaviours should be assessed by registered staff and documented in the assessment tab of the home's electronic documentation system.

A) According to interviews on August 3, 2017, with Personal Care Providers (PCPs) #149, #151, and #147, resident #027 had been demonstrating responsive behaviours that were not easily altered. RPN #112 described possible causes of the behaviour and stated that they had not tracked or conducted a responsive behaviour assessment to determine behavioural triggers, or documented this in the resident's health record. The DOC confirmed that only after interviews with the Long Term Care Homes (LTC) Inspector was the resident assessed to identify triggers and develop strategies to respond to these behaviours.

B) According to their health record, resident #028 had been exhibiting responsive behaviours, were assessed and were receiving treatment. On a specified day following the initiation of this treatment, they were observed exhibiting a new behaviour. Review of the health record revealed that they had not been assessed by registered staff to determine the possible triggers for this behaviour. RN #101 and the DOC confirmed that resident #028's new responsive behaviours should have been assessed so that potential triggers could be identified and strategies set out and implemented.

C) Review of health records and interview with PCPs #161 and #159 and RPN #113 revealed that resident #029 had been exhibiting a responsive behaviour for a period of time. A strategy to address the behaviour was found to be unsuccessful and a new strategy tried. Registered staff reported that the new strategy was effective while Personal Care Provider staff reported that the strategy was not effective. RPN #113 confirmed that registered staff had not assessed resident #029 when they were exhibiting the identified behaviours within at least the previous six months. RPN #113, RN #101 who was the Responsive Behaviour lead in the home, and the DOC confirmed that staff failed to assess resident #029's resistance to care for triggers that may have caused the resident to demonstrate resistance to care over an identified time period of three months in 2017, and when there as a change in the identified trigger on an identified date. [s. 53. (4)]

Additional Required Actions:

CO # - 008, 009 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.

WN #9: 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, 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 complied with.

A) In accordance with O. Reg. 79/10, s. 30(1) and 30(1) 1, the licensee was required to have an organized program for falls prevention and management that included relevant policy and procedures.

The licensee failed to ensure that staff complied with the licensee's policy and procedure located in the Resident Services Manual and identified as section 4.1 Resident Rights and Safety, subsection 4.1.12 Falls Prevention Program with a reviewed date of July 2017.

The licensee's procedure directed:
a) Following completion of a Falls Risk Assessment after any fall, staff were to develop interventions to address residents identified as high risk and implement an interdisciplinary plan of care.

The Director of Care (DOC), registered staff #111 and resident #021's clinical record confirmed that staff did not comply with the above noted direction when it was identified that the resident's risk of falling increased. A review of the resident's plan of care indicated that no new care interventions had been added to the resident's plan of care since before the fall and staff had not developed or implemented interventions to manage the identified increased risk of falling.

B) In accordance with s. 21., the licensee shall ensure that there were written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

The licensee failed to ensure that staff complied with the licensee's policy "Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes" identified as section 4.2, subsection 4.2.10, last revised in May 2017.

A review was completed of the eight (8) complaints received from the home's compliance date of July 14, until August 14, 2017 the last date a complaint was received by the home at the time of the inspection. The procedure within this policy directed as follows:

a) Every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1d) The Administrator shall add the basic complaint information to the complaint log, then forward the complaint to the relevant Department Manager for investigation.

The Administrator did not comply with this direction when he acknowledged that the expectation is that the Administrator sign and date all of the complaint forms at the bottom of page one, before forwarding the complaint to the relevant Department Manager for investigation. A review completed with the Administrator of the ten logged complaints received identified, eight of ten of the home's suggestions, concerns and complaints forms had not been signed by the Administrator. The inspector also confirmed with the Administrator that four of the complaint forms had been signed by other staff members in the home.

b) Every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1g) A written response must be provided to the person making the complaint within 10 business days of the receipt of the complaint. For example:

Staff did not comply with this direction when the Administrator confirmed that providing a written response, applies to all written complaints however, not those the home can resolve before it becomes a written complaint. The Administrator then confirmed that the only complaints that had a written response, were those that were done through email as that was the complainant's choice of correspondence.

c) The Administrator shall ensure that all suggestions, complaints and concerns are

documented and a record is maintained within the home that includes: 2d) The final resolution, if any.

Staff did not comply with this direction when the Administrator confirmed that two out of eight of the home's suggestions, concerns and complaints forms had no final resolution were one was required.

d) The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: 2e) Every date on which any response was provided to the complainant and a description of the response.

Staff did not comply with this direction when the Administrator confirmed that five of eight of the home's suggestions, concerns and complaints forms were blank in regards to every date on which any response was provided to the complainant and a description of the response.

e) The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: 2f) Any response made in turn by the complainant.

Staff did not comply with this direction when the Administrator stated that they could not confirmed if complainants had responded and that six of eight of the home's suggestions. The section of the concerns and complaints forms where it indicated if a response was made by the complainant was left blank.

The Administrator also confirmed at the time of the interview with the inspector that he was utilizing the home's policy last reviewed March 2016 and that he had not received training on the May 2017 revised policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 010 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.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

This inspection was completed as a follow up to Compliance Order #006, inspection number 2017_587129_0002 (A1), regarding O.Reg 79/10, s. 8. (1)b in relation to staff complying with the home's responsive behaviour policy.

The home's "Residents with Special Needs" "Responsive Behaviour Management, Behavioural Support Program" policy, number 4.11.10 last reviewed May 17, 2017 was available to staff and staff were educated on the policy prior to July 14, 2017. The policy related specifically to residents exhibiting severe escalating responsive behaviours and was the only responsive behaviour policy provided to LTC inspectors during this follow up inspection.

Review of progress notes and interview with Registered Practical Nurse (RPN) #118 revealed that resident #037 exhibited responsive behaviours that involved two altercations involving other residents. The RPN confirmed that the "Responsive Behaviour Management, Behavioural Support Program" policy number 4.11.10 last reviewed May 17, 2017, directed staff actions in relation to the incidents that resulted

from resident #037's behaviours. Review of health records for resident #037 revealed that staff had failed to comply with this policy as follows:

i)) The policy directed staff to "7. Assess the resident and commence the assessment tools to track behaviour including any triggers for the behaviours exhibited". The resident's paper and electronic health record did not contain completed assessment or tracking tools in relation to either of these incidents according to the home's policy. This was confirmed by RPN #118 and the Assistant Director of Care (ADOC).

ii) The policy directed staff to "9. Review and revise the plan of care and develop short and long term goals using all members of the interdisciplinary team". Review of the most recent document the home referred to as the care plan, revealed that it had not been updated to include goals and interventions to address resident #037's after the second altercation. The ADOC confirmed this, stating that interventions should have been put in place immediately after the first incident.

The ADOC confirmed that staff did not comply with the home's "Responsive Behaviour Management, Behavioural Support Program" policy in relation to management of resident #037's responsive behaviours. [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 15th day of September, 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) :	THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2017_551526_0014
Log No. / No de registre :	008331-17, 008332-17, 010137-17, 010138-17, 010139-17, 010141-17, 010142-17, 010143-17, 010144-17, 010145-17, 010146-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 14, 2017
Licensee / Titulaire de permis :	BELLA SENIOR CARE RESIDENCES INC. 1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5
LTC Home / Foyer de SLD :	BELLA SENIOR CARE RESIDENCES INC. 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael Bausch

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_587129_0002, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement under s. 6(10) to ensure that the residents are 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; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (2) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of potential for actual harm experienced by three residents, the scope a pattern of incidents and the licensee's history of noncompliance that included the issuing of two Written Notifications in March 2015 and November 2016, two Voluntary Plans of Correction in February 2015, March 2016, two Compliance Orders in July 2016 and June 2017, and two

Directors Reviews July 2016 and June 2017.

2. The licensee failed to comply with compliance order #002 s.6(10) , inspection report #2017_587129_0002 (A1). The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall provide training to all staff involved in the assessment/reassessment of residents. The training is to include the steps staff are to follow when reassessing a resident, the relationship between the established goals of care and the timing of reassessments, how to identify that the care being provided to the resident has not been successful, where assessment/reassessment data is to be documented and the requirement to review and revise the plan of care following a reassessment. AND

B) The licensee shall develop and implement a schedule for monitoring staff's performance in complying with directions for the assessment/reassessment of residents.

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 the resident's care needs change or care set out in the plan was no longer necessary.

A) Resident #003 had a health condition that affected their continence. The resident was reassessed and demonstrated a decline in their continence status. Review of their health records interviews with registered staff revealed that the plan of care to direct care interventions had not been reviewed or updated to address the resident's care needs that resulted from this change.

B) Resident #004 demonstrated a change in their level of continence and in the care required. Review of the plan of care and interviews with staff revealed that the plan of care had not been reviewed or updated to reflect this change, or interventions identified to assist resident #004 with their current continence needs. [s. 6. (10) (b)]

4. 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 c) care set out in the plan had not been effective.

The Director of Care (DOC), registered staff #111 and resident #021's clinical record confirmed that the plan of care had not been reviewed or revised when it was identified that the interventions in place related to falls had not been effective. The care interventions identified in resident #021's plan of care had not been effective in attaining the identified goals of care, the resident continued to fall and the resident's plan of care had not been reviewed or revised despite the care being provided to the resident to manage falls not being effective. [s. 6. (10) (c)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2017

Order # / Ordre no : 002

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 :

The licensee shall do the following: ensure that residents are protected from abuse by anyone including during resident to resident altercations.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (3), scope (1) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of actual harm experienced by one resident, the scope of isolated incidents and the licensee's history of noncompliance that included the issuing of one Voluntary Plan of Correction in October 2016, and two Compliance Orders in July 2015 and November 2016.

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

Review of progress notes and interviews with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN) #124 and recreation staff #215 revealed that, on a specified day in 2017, resident #009 became physically responsive toward resident #001. Recreation staff #215 intervened, informed registered staff who assessed the resident and documented an injury that they observed on resident #001 that appeared to occur during the altercation. In addition, RPN #124 reported that resident #001 expressed being upset following the incident.

RPNs #124 and #111 and RN #106 stated that these two residents demonstrated responsive behaviours under certain circumstances and it was these circumstances that triggered the incident. Review of resident #001's plan of care revealed that it did not address the risk for altercations and/or resident to

resident abuse that resident #001's behaviour might have triggered, especially when it was known that the behaviour may directly trigger #009's responsive behaviours. During interview, Registered Nurse #101 confirmed that the altercation between residents #001 and #009 resulted in physical abuse to resident #001.

During interview, the Director of Care (DOC) confirmed that a risk for altercations existed between residents #001 and #009, interventions were not in place to fully address this risk, resident #001 had been injured during an altercation with resident #009, that this constituted physical abuse and that staff failed to protect residents from abuse. [s. 19. (1)]

RPNs #124 and #111 and RN #106 also stated that resident #001 would enter resident #009's room often. Strategies to prevent residents from entering the room had been tried and were unsuccessful. Resident #001 was known to exhibit physical and verbal aggression toward co-residents. Resident #001's wandering behaviour several times per day (6/7) had been identified as "very much" disruptive (4/6) during a Cohen Mansfield Agitation Inventory assessment conducted on May 5, 2017. Despite this, RPN #111 confirmed that the plan of care did not address the risk for altercations and/or resident to resident abuse that resident #001's wandering might have triggered, especially when it was known they wandered into resident #009's room, and that this triggered a response from resident #009. RPN #111 stated that all residents on Willoughby home area wandered and that this was a normal occurrence. During interview, Registered Nurse #101 confirmed that the altercation between residents #001 and #009 resulted in physical abuse to resident #001.

During interview, the Director of Care (DOC) confirmed that a risk for altercations existed between residents #001 and #009, that interventions were not in place to fully address this risk, that resident #001 had been injured during an altercation with resident #009, that this constituted physical abuse and that staff failed to protect residents from abuse.
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 22, 2017

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2017_587129_0002, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the there is in place a written policy to promote zero tolerance of abuse and neglect of residents that complies with regulatory requirements, and that the policy is complied with.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (2) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm, the scope of a pattern of incidents and the licensee's history of non-compliance that included the issuing of five Voluntary Plans of Correction in May 2015, March 2016, June 2016, November 2016, and October 2016 and one Compliance Order in May 2017.

2. The licensee failed to comply with compliance order #003, s. 20(1), inspection report #2017_587129_0002 (A1). The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall review and were necessary revise the policies and

procedures related to Abuse and Neglect Prevention.

B) The licensee shall provide training for all staff related to the policies and procedures noted above. Attendance records are to be maintained in relation to this training.

C) The licensee shall develop and implement a program for monitoring staff's performance in complying with the licensee's policy.

3. The licensee has failed to ensure that staff complied with the licensee's policy "Abuse and Neglect Prevention" identified as section: 4.1, subsection 4.12, last reviewed in May 2017.

This policy directed "All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care [DOC] or the Administrator".

On a specified day in 2017, Personal Care Provider (PCP) #214 called the Director of Care (DOC) and advised them that approximately 14 days earlier, they were a witness to an incident of verbal abuse by staff #191 toward an identified resident. Following the home's investigation, verbal abuse could not be verified. However, the DOC confirmed that PCP #214 was disciplined for failure to report the alleged incident of verbal abuse according to the home's policy. The DOC confirmed that the licensee failed to ensure that staff complied with the home's policy on abuse. [s. 20. (1)]

4. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Review of the home's Resident Rights and Safety policy "Abuse and Neglect Prevention" identified as section 4.1, subsection 4.1.2 and last reviewed in May 2015, directed staff as follows:

"Any 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 their Supervisor, the Director of Care or the Administrator:...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";

"All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator";

"The following persons are guilty of an offense under the Long Term Care Homes Act if the fail to make a report required by legislation:
1. The Home or a Management Company
2. If the Home is licensed or managed by a corporation; the Corporation, an officer or the director of
the corporation
3. Any staff member
4. Any person who provides professional services to a resident in the areas of health, social work or
social services work"; and

"The Administrator/Designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System, or via pager (after hours or holidays)".

During interview, Registered Nurse #101 stated that they used to call the Director via the after hours phone, but recently, had been instructed to inform the DOC or ADOC about suspected or actual abuse and not initiate reports themselves. They said that they were somewhat confused about their duty to report suspected or actual abuse to the Director.

During interview, the Nurse Consultant confirmed that they revised the home's "Abuse and Neglect Prevention" policy in May 2017. During interview, the Director of Care (DOC), and the Assistant DOC (ADOC) were questioned about the home's policy that contained an explanation of the duty under section 24 of the Act to make mandatory reports, to direct any person who had reasonable grounds to suspect that any of items listed in section 24(1) of the Act had occurred or may occur, to immediately report the suspicion and the information upon which it was based to the Director. The DOC stated that previously, the policy directed all staff to report suspected or actual abuse to the Director and this resulted in reporting of incidents that did not fit the legislative definition of abuse. The policy was changed to reflect a process in the home that required

staff to report to registered staff, who would then report to the DOC or ADOC, who would then report to the Director. They confirmed that the "Abuse and Neglect Prevention" policy did not fully comply with section 24 of the Act that any person had a duty to immediately report the suspicion and the information upon which it was based to the Director. [s. 20. (2)] (536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 12, 2017

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant:
2016_250511_0011, CO #004;
2017_587129_0002, CO #004;

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 prepare, submit and implement a plan to ensure the development and implementation of 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.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (3) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the minimal harm/potential for actual harm, the widespread scope of the non-compliance and the licensee's history of non-compliance that included the issuing of a Compliance Order in November 2016 and May 2017.

2. The licensee failed to comply with compliance order #004, 2007, c. 8, s. 84., inspection report #2017_587129_0002 (A1). The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall review and were necessary revise the policies and procedures that make up the quality improvement and utilization review system.

B) The licensee shall implement the quality improvement and utilization review system, ensure that activities are being monitored and documentation is maintained to demonstrate the policies and procedures are being followed and all the quality activities that are required in the LTCH Act 2007 and the associated Regulations are complied with.

In accordance with this compliance order, the licensee failed to maintain documentation to demonstrate the policies and procedures were being followed and all the quality activities that were required in the LTCH Act 2007 and the associated Regulations were complied with.

3. The licensee failed to implement 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 of the long-term care home.

Directions for implementation of the licensee's quality improvement and utilization review system were identified in the following documents located in the Bella Senior Care Residence Quality and Risk Management Policies and Procedures Manual:
"Quality Process", identified as section 1.0, subsection 1.2 and last reviewed in September 2011;
"Organizational Chart", identified as section 2.0, subsection 2.1 and last reviewed April 2017;
"Quality Committee", identified as section 3.0, subsection 3.1 and last reviewed/revised in August 2017;
"Quality Indicators", identified as section 4.0, subsection 4.1 and last reviewed/revised August 2017;
"Quality Audits", identified as section 5.0, subsection 5.1 and last reviewed/revised August 2017;
"Quality Projects", identified as section 6.0, subsection 6.1 and last reviewed September 2011;
"Benchmarking", identified as section 7.0, subsection 7.1 and last reviewed September 2011;
"Risk Management", identified as section 8.0, subsection 8.1 and last reviewed September 2017;

"Lockout and Tag out of equipment", identified as section 8.0, subsection 8.2 and created March 2013; and the following audit templates: 17 Administrative, 28 Nursing, 11 Nutrition Services, and 5 Infection Control.

A) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Process".

i) The "Quality Process" policy identified a quality improvement process that included: selection and/or modification of indicators, audits or projects; set up routine data collection methods for each critical indicator as a Quality Plan; record the monitoring results and provide some analysis; initiate problem solving activities when variations are flagged and subsequently identified as a pattern or trend in the data; evaluate each indicator to determine the usefulness of the indicator and report the results of monitoring activities in a statistical and descriptive format to staff, teams and the Board.

The Administrator stated that they realized the seriousness of the home's legislative non-compliance in relation to the home's quality improvement and utilization review system only after Inspection number 2017_587129_0002 that was served on May 11, 2017. It was at approximately that time that steps were taken to address the deficiencies in the home's quality improvement and utilization review system that had been identified during that inspection. According to the home's Director of Care (DOC), Assistant DOC and Nurse Consultant, implementation of the home's Quality Process policy was in the beginning stages.

As of the time of this inspection, the DOC reported that there had been four Quality Council meetings beginning May 3, 2017, during which time Council members stated that they did not know what quality indicators were and that they were not conducting quality audits. Since that time, the Council had developed a proposed terms of reference, had received education about the home's quality improvement and utilization review system including quality indicators and audits, and they began to select relevant quality indicators for the purposes of auditing. During the August 1, 2017 meeting, the Performance Indicator History Summary generated from PCC (June 2017) was reviewed and preliminary improvement strategies discussed. The DOC stated that these data had not been analyzed but would be formally analyzed at the end of the current

quarter.

ii) The home's "Quality Process" policy included the "Improvement Plan Process" that directed staff to work in a team according to the needs of the organization, to define a problem, analyze the problem's cause, generate solutions and develop an improvement plan. Implementation of the quality process was not interdisciplinary as follows:

-The Nurse Consultant who was contracted to oversee the home's quality improvement and utilization review system described their actions and they included the review of care plans to make update recommendations. They stated that the information was gathered independently, and was communicated via email to the DOC and verbally to the DOC and staff; however, emails were not provided. While, the reviews were provided to Long Term Care Homes (LTC) Inspectors; a summary quality analysis of the care plan review and recommendations were not provided.

-Programme evaluations for Wound and Skin Care, Continence Improvement, and Falls Prevention and Restraint Reduction for data ending April 2017, and for Responsive Behaviour Management for data ending June, 2017, were provided to the LTC inspectors. According to interviews with the Nurse Consultant and the DOC, these evaluations were completed independently by the Nurse Consultant on June 19, 2017, and not by an interdisciplinary team/Quality Team or DOC/ADOC to review, analyze or develop strategies according to the home's quality improvement and utilization review system.

iii) The plan for corrective action developed by the home and submitted to the Ministry in response to inspection 2017_587129_0002 following a compliance order served to the home on May 11, 2017, related to continuous quality improvement, indicated: "d) Quality Indicators identified by Quality Council with Quality Leads inputting quality data into PCC QIA module";" e) Quality Council to review Quality Indicators to identify trends in data and develop an action plan to improve quality services and programs for residents"; and "3. Administrator to submit quality report to Owner and ACC (Assured Care Consulting) monthly outlining all meetings, and data from quality improvement teams".

Review of documents provided by the home and interviews with the Owner, ACC President, Nurse Consultant, Administrator, DOC and ADOC revealed that all quality indicators had not been developed, audited, reviewed, or analyzed for

recommendations and strategies. In addition, quality reports outlining all meetings, and data from quality improvement teams were not submitted to the Owner and ACC. No reports as indicated in the plan of correction were developed or provided to LTC Inspectors upon request.

B) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Committee".

i) The preamble of the "Quality Committee" policy set out a structure to be implemented to ensure the governance responsibilities for quality improvement were fulfilled. The structure identified that the governing body (licensee) had the ultimate responsibility for the quality of care and services and the management of risk. The licensee delegated quality management oversight to the Management Company. During interview the licensee stated that they had general conversations and exchanged emails about the home with the Management Company. They spent time in the home interacting with staff and residents however they stated that they trusted the administrative team and Management Company to manage quality in the home. They were not provided quality reports by the Management Company and could not provide examples or documentation regarding any quality issues.

-The Management Company was staffed by the President of the company, and they attended the home approximately weekly. They had hired an interim Administrator, Nurse Consultant, and Dietary Consultant to operate the home. Meetings and/or conversations between these people and with the licensee were not documented. The Management Company President stated that the Nurse Consultant was their delegate for all quality issues in the home, that their own expertise was not health related and that they felt unable to speak to the quality of care of residents in the home. The President of the Management Company stated that they monitored the following quality indicators: complaints from families and residents, labour issues, and physical plant of the building. They stated that the quality of the Nurse Consultant's management of the quality improvement and utilization review system was not assessed or evaluated.

- According to the Management Company President and the Nurse Consultant, the Nurse Consultant was hired by the Management Company to oversee the home's quality improvement and utilization review system. The Nurse

Consultant confirmed they had not provided quality reports to the Management Company, the Administrator or the Licensee. According to the Nurse Consultant, they delegated the implementation of care related aspects of the quality improvement and utilization review system and addressing legislative non-compliance to the Director of Care (DOC). They implemented a review of resident plans of care, updated policies and produced annual programme reviews. They confirmed that they attended two out of four (2/4) quality meetings. They provided documentation regarding their review of the plans of care of every resident in the home, but did not include an analysis of this review or home wide strategies to address plan of care deficiencies.

ii) The Preamble of the "Quality Committee" policy indicated that the Management Company delegated responsibility and authority for the quality improvement and utilization review system to the Administrator. The Management Company was to delegate day to day operational responsibility to the Administrator, who, with the support of the Quality Committee and senior leadership was to submit quarterly reports to the Manager on quality improvement initiatives and activities for managing risk. The responsibility and authority for executing the components of the quality system and procedures were to be delegated to the Quality Care Teams.

The Administrator had been hired by the Management Company since December 2016. The Administrator stated that they delegated care related aspects of the quality improvement and utilization review system to the DOC including the monitoring of Quality Care Teams' activities. They said that they only focused on non-care issues such as Laundry, Housekeeping, Maintenance, and labour relations issues. The Administrator could not comment on specific aspects of the home's quality improvement and utilization review system in relation to care of residents. They confirmed that they had not submitted quarterly reports to the Management Company on quality improvement initiatives and activities for managing risk. They did not normally attend Quality Council meetings.

iii) The Preamble of the "Quality Committee" policy indicated that the Management Company was to receive reports and provide feedback to the Administrator on issues and accomplishments related to quality improvement. During interviews, the Management Company President, Nurse Consultant, Administrator, and DOC confirmed that verbal reports and feedback were exchanged on an ongoing basis. However, these conversations were not

documented to demonstrate the implementation of the home's policy. No written reports were provided to the Management Company, and the Administrator and President of the Management Company could not provide documentation that indicated their familiarity with the home's quality improvement and utilization review system.

iv) The Preamble of the "Quality Committee" policy indicated that the Management Company was to direct, co-ordinate, and provide for ongoing development of the quality improvement philosophy and plan for the home. The Nurse Consultant was delegated to fulfill this Management Company function. However, interviews and review of documents provided by the home, revealed that the ongoing development of the quality improvement activities in the home was not coordinated between all staff involved as follows:

- The Management Company President and Administrator could not speak to specifics of the home's quality improvement and utilization review system. They described the home's current approach to the home's quality improvement and utilization review system as "hands on" and reactive to legislative non-compliance and resident/family complaints.

- The Nurse Consultant who was the Management Company's quality management delegate failed to attend two out of four Quality Council meetings held between May and August 2017 stating that they were not working in the home on the days of the meetings.

- The Nurse Consultant produced programme evaluations for the wound and skin care, responsive behaviours, continence improvement, and falls prevention programmes that demonstrated a lack of interdisciplinary coordination with the DOC, ADOC, and respective Quality Teams.

- The Nurse Consultant produced a "Quality Score Card" on August 31, 2017, dated June 2017, that was not provided by the home during the onsite follow up inspection for compliance order #004 in relation to LTCHA, 2007, s. 84, conducted between July 25 and August 25, 2017. During this time, the President of the Management Company, the Administrator, the Nurse Consultant and DOC were asked for any and all documents related to the home's quality improvement and utilization review system and this document was not provided until after the inspection team had completed the onsite inspection.

- The Nurse Consultant reviewed and revised the home's Safe Handling and Assessing Residents , Bowel and Bladder Management, and Responsive Behaviour Management policies without collaboration with the DOC or respective Quality Teams.

- The Nurse Consultant reviewed the home's "Abuse and Neglect Prevention Program" policy after which time the policy did not meet legislative requirements under section 20(2) in the Act;

- A consulting dietitian reviewed and revised the home's Nutrition and Hydration policies that were approved by the Management Company President and implemented in March 2017. This was conducted without the knowledge or collaboration with the DOC or Registered Dietitians who were staff in the home. The policies were pulled out of circulation by the DOC in July 2017 when they learned that they had been updated and implemented without their knowledge, since directions in the policies conflicted with current nursing practice.

- The DOC and ADOC modified the home's Hydration Program policy without collaboration with the Nurse Consultant, or Registered Dietitians who were staff in the home.

v) The Procedure for the "Quality Committee" policy indicated that the Administrator shall: "a) chair the Quality Committee as available, b) schedule meetings quarterly or more frequently at the call of the Chair, c) be responsible for scheduling meetings, formulating the agenda and conducting the meeting, d) support the establishment of Quality Project Teams and confirm the selection of a Coach to support the team, e) review regular update from the project team on the progress of the quality activities, f) coordinate regular communications to the Management Company and Owner, and g) ensure appropriate rewards and recognition for successful improvement activities." During interview, the DOC and Administrator confirmed that the Administrator had not been complying with items a) through e), regarding their role in the "Quality Committee" policy. The DOC stated that when these functions were not implemented by the Administrator, they took them on to ensure that the work was completed.

At the time of this inspection the licensee had not ensured that the structure identified in the "Quality Committee" policy had been implemented.

C) The Licensee, the Management Company and the Administrator failed to

implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Indicators", identified as section 4.0, subsection 4.1 and last reviewed/revised August 2017. Review of the home's "Quality Indicators" policy directed staff to track defined indicators quarterly or monthly as specified from the home's Point Click Care Quality Improvement Administrator program. During interviews, the DOC and Nurse Consultant indicated that the program can produce reports on selected indicators, however they confirmed that Quality Teams and program managers were in the process of determining which quality indicators would be most helpful to routinely collect. The Quality Council and Quality Care Teams had not conducted quarterly analysis of all indicators as of this inspection.

D) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Audits", identified as section 5.0, subsection 5.1 and last reviewed/revised August 2017. Review of the home's "Quality Audits" outlined the standard routine annual and quarterly audits that should be conducted in the home for the following systems: Administration, Nursing Services, Documentation, Infection Control, Recreation and Leisure, Volunteer Services, Dietary, Environmental, Accounting, Human Resources, Occupational Health and Safety, and Pharmacy and Medication Services. During interview, the DOC and Nurse Consultant indicated that members of the Quality Council were in the process of determining what indicators they wanted to audit to inform the extent to which all systems in the home were effective and efficient. Documentation was provided for the following audits currently being conducted in the home:

• Personal Care Provider (PCP) Focused Audits that contained monitoring of PCP responsibilities;
• Nursing Department Safety Audits;
• Room Audits;
• Monthly care plan audits: one for each resident monthly on a schedule
• Recreations audits;
• Fridge, Freezer and Food temperature audits;
• Room and building temperature audits;
• Water temperature audits;
• Monthly safety inspection checklists;

During interview, the DOC and Nurse Consultant confirmed that while audits were completed for Medication Management and Falls Prevention, the home had not been conducting all audits according to the home's policy. In addition, The DOC confirmed that the data gathered in these audits had not been analyzed for trends, recommendations created, or strategies implemented.

E) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policies as follows:
i) "Quality Projects" identified as section 6.0, subsection 6.1 and last reviewed/revised September 2011;
ii) "Benchmarking" identified as section 7.0, subsection 7.1 and last reviewed/revised September 2011; and
iii) "Risk Management" identified as section 8.0, subsection 8.1 and last reviewed/revised September 2011.

During interviews, the DOC and Nurse Consultant confirmed that these policies had not been reviewed or revised in 2017. The Nurse Consultant and President of the Management Company indicated that the home had submitted Quality Improvement Plans (QIP) to the Local Health Integration Network as required. However, the Nurse Consultant and DOC confirmed that the home had not complied with the "Quality Projects", "Benchmarking", or "Risk Management" policies as part of the home's quality improvement and utilization review system.

During interviews, the President of the Management Company, the Administrator, the Nurse Consultant, the DOC and ADOC indicated that the home's quality improvement and utilization review system that monitored, analyzes, evaluated and improved the quality of the accommodation, care services, programs and goods provided to residents was in a developmental phase and confirmed the system had not been fully implemented.
(526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2017_587129_0002, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (3), scope (3) and compliance history (3) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of actual harm to one resident reviewed, the scope of a pattern of incidents and the licensee's history of noncompliance related to the management of responsive behaviours including two Written Notifications in May 2015 and March 2016, two Voluntary Plans of Correction in May 2016 and August 2016 and a Compliance Order in May 2016 non-compliance with

regulations related to the management of responsive behaviours.

2. The licensee failed to comply with compliance order #009 O. Reg. 79/10, s. 54, inspection report #2017_587129_0002 (A1). The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall reassess all residents, including resident #009 and resident #010, who demonstrate responsive behaviours that have the potential to result in potentially harmful interactions between and among residents.

B) For all residents noted above behavioural triggers are to be identified, where possible, and interventions designed to reduce the risk of harmful interactions between residents are to be included in each residents plan of care and implemented.

C) The licensee is to develop and implement a regular schedule monitoring the effectiveness of the interventions implemented to reduce the risk of harmful interactions between residents.

3. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Review of health records revealed that resident #001 and #009 were identified as having responsive behaviours that increased the risk for altercations and potentially harmful interactions between residents. Resident #001's health record revealed that suggested interventions to prevent altercations were not routinely implemented or documented. Interventions to prevent resident #009's behaviours that may lead to altercations were known to not be effective. RPN #111 stated that resident #001 and #009's behaviours could trigger responsive behaviours and potentially harmful interactions between residents.

Review of progress notes and interviews with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN) #124 and recreation staff #215 revealed that, on a specified day in 2017, there was an altercation between two residents that resulted in injury to one of the residents. In addition, RPN #124 reported that the injured resident expressed being upset following the incident. During interview, RPN #124, RN #106, the Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed that the resident suffered abuse when

they were injured as the result of an altercation with resident #009.

Resident #001's health records revealed that they had not been reassessed until almost one month after the incident to confirm that their behaviours could trigger altercations and that this was potentially harmful to residents, particularly between them and resident #009. During interview, RPN #111 stated that many residents on the home area exhibited similar behaviours and a normal occurrence. RN #101 and the Nurse Consultant both indicated that these behaviours were a normal part of dementia and should not cause harm to other residents.

Health records and interviews with RPN #124 and #111 confirmed that prior to the incident between resident's #001 and #009, resident #001's plan of care did not include strategies to prevent altercations between the two residents. They stated that they had not thought to reassess resident #001's behaviours or to update their plan of care and that, after discussing it with the Long Term Care Home's inspector, they recognized that resident #001's behaviours triggered an altercation between the two residents. The Director of Care (DOC) confirmed that resident #001 had not been reassessed or their plan of care updated to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54.] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 12, 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 : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (3) and compliance history (3) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of potential for actual harm experienced by 4 residents, the scope widespread of incidents and the licensee's history of related

noncompliance that included the areas related to staff compliance with nutrition and hydration policies under O. Reg. 79/10, s. 8(1)(b).

2. The licensee failed to ensure that the nutrition care and hydration programs included the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration, in consultation with a dietitian who was a member of the staff.

Review of the home's "Feeding and Hydration - Hydration Program" number 4.9.1, reviewed and revised July 2017, outlined the following direction regarding monitoring and evaluating fluid intake of residents:

"If the resident's fluid intake is below their fluid needs for three consecutive days, the resident will be placed on Fluid Watch" and

"Residents who do not consume 1000 ml for 3 consecutive days will be placed on Fluid Watch: the Registered Staff will activate the Fluid Watch task in POC to alert nursing staff of the need for increased fluids, promoting extra fluids to be offered throughout the day. A Dietary Referral is to be sent to the FSM/RD to communicate that the Fluid Watch has been stated and the FSM/RD will update the care plan."

A) Review of resident health records revealed that residents #045, #007, #046, and #033 were on fluid watch and were referred for Registered Dietitian consultation by Registered Nurse (RN) #103, in relation to their fluid and hydration needs.

During interview, RN #103 said the home's process for placing a resident on fluid watch and RD referral required that they review a report that was generated during the previous night shift. The report identified which residents fell below their fluid need requirements so that a RD referral could be initiated by the RN working during the day shift. A notation on the report indicated that a RD referral should be made only if residents' fluid intake fell below 1000 ml for three consecutive days. The RN stated that they were not aware of this new policy until the RD spoke with them on the day of the interview. They confirmed that their process and practice had been different than what was written in the home's "Feeding and Hydration - Hydration Program" policy.

During interview on August 22, 2017, the home's two Registered Dietitians (RD)

stated that they had not been consulted and had not seen this policy until the day of this interview. They confirmed that the policy was confusing since the staff were directed to initiate a fluid watch both when a resident's fluid intake was less than their daily need for three consecutive days, and also when the fluid intake was less than 1000 ml for three consecutive days. They stated that there should have been revisions that would include more clarity about when a fluid watch should be initiated and that staff should be directed to refer to a resident's plan of care for an individualized minimum fluid intake amount that should trigger initiation of a fluid watch and referral to a RD. They also stated that the automatic trigger that alerted registered staff about low fluid intakes had not been reset to 1000 ml and so continued to prompt a RD referral based on the home's previous policy. The two RDs in the home stated that staff had not complied with the home's Hydration Program policy when they initiated a RD referral when a resident's fluid intake was not less than 1000 ml, or according to their plan of care, for three consecutive days.

B) During interview, the external Consulting Dietitian indicated that they had reviewed the policy but had not consulted the RDs in the home. The Director of Care (DOC) stated that they had reviewed the Hydration Program policy and directed the Assistant DOC to revise it to reflect that RD referrals should only be made when a resident's fluid intake fell below 1000 ml for three consecutive days; before the policy could be reviewed by the RDs who were staff in the home, all staff in the home were educated on the policy and the policy was implemented.

The DOC also stated that during March 2017, the home's Feeding and Hydration policies were updated by a consulting RD without input from the RDs who were members of the staff in the home, then approved by the home's Management Company and provided to the Food Services Manager for implementation. The DOC confirmed that the home had failed to comply with legislative requirement that nutrition care and hydration policies be developed and implemented in consultation with RDs who were staff in the home. [s. 68. (2) (a)] (526)

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that 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.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (1) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of potential for actual harm experienced by one resident, the scope of isolated incidents and the licensee's history of noncompliance that included the issuing of three Voluntary Plans of Correction (VPCs) in July, November 2016, and January and July 2016.

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

Resident #003 had a health condition that affected their continence. Review of their health records interviews with registered staff revealed that the plan of care to direct care interventions had not been reviewed or updated to address this change.

During interview, the RAI Coordinator indicated that the resident's change in continence would have warranted a continence assessment using the clinically appropriate instrument that was designed for assessment of incontinence and that was found in the assessment tab of the home's electronic documentation system. Review of the assessment tab revealed that no continence assessment had been completed. [s. 51. (2) (a)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 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 : 008

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

Linked to Existing Order / Lien vers ordre existant:
2016_250511_0011, CO #007;
2017_569508_0004, CO #002;
2017_587129_0002, CO #009;

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 prepare, submit and implement a plan to 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.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (3) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of potential for actual harm experienced by three residents, the scope widespread of incidents and the licensee's history of noncompliance that included non compliance in relation to O. Reg. 79/10, s. 53

(4) as follows: two Written Notifications (WNs) issued in May 2015 and April 2016, two Voluntary Plans of Correction (VPCs) issued in July 2016 and October 2016 and five Compliance Orders (COs) issued in May and November 2016, March 2017 and twice in May 2017.

2. The licensee failed to comply with compliance order #009 O. Reg. 79/10, s. 53(4), inspection report #2017_587129_0002 (A1). The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall revise the policies and procedures that make up the program for the management of responsive behaviours to include a method for documenting responsive behaviours that will allow behavioural data to be collected and analyzed.

B) The licensee is to provide training to all staff who provide direct care to residents related to the policies, processes and practices identified in the program for the management of responsive behaviours. Attendance records for this training are to be maintained.

C) The licensee shall reassess all residents who demonstrate responsive behaviours, review and revise each resident's plan of care to ensure identified triggers for the behaviours, reasonable goals of care have been identified and resident specific care interventions are in place to manage behaviours being demonstrated.

D) The licensee will develop and implement a system for monitoring staff's performance in complying with the policies and procedures as well as track the success of the effectiveness in managing responsive behaviours.

3. The licensee failed to comply with compliance order #002. Reg. 79/10, s. 53(4), inspection report #2017_569508_0004. The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall ensure that all direct care staff, including agency staff receive retraining on the home's Responsive Behaviour program.

4. The licensee failed to ensure that for each resident demonstrating responsive behaviours that behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to the

behaviours, where possible and actions were taken to respond to the needs of the resident, including assessments and reassessments.

During interviews, Registered Practical Nurses (RPNs) #112, #113, and #123, Registered Nurse #101 who was the Responsive Behaviour lead in the home, the Director of Care (DOC) and Assistant DOC stated that residents demonstrating responsive behaviours should be assessed by registered staff and documented in the assessment tab of the home's electronic documentation system.

A) According to interviews on August 3, 2017, with Personal Care Providers (PCPs) #149, #151 and #147, resident #027 had been demonstrating responsive behaviours that were not easily altered. RPN #112 described possible causes of the behaviour and stated that they had not tracked or conducted a responsive behaviour assessment to determine behavioural triggers, or documented this in the resident's health record. The DOC confirmed that only after interviews with the Long Term Care Homes (LTC) Inspector was the resident assessed to identify triggers and develop strategies to respond to these behaviours.

B) According to their health record, resident #028 had been exhibiting responsive behaviours, were assessed and were receiving treatment. On a specified day following the initiation of this treatment, they were observed exhibiting a new behaviour. Review of the health record revealed that they had not been assessed by registered staff to determine the possible triggers for this behaviour. RN #101 and the DOC confirmed that resident #028's new responsive behaviours should have been assessed so that potential triggers could be identified and strategies set out and implemented.

C) Review of health records and interview with PCPs #161 and #159 and RPN #113 revealed that resident #029 had been exhibiting a responsive behaviour for a period of time. A strategy to address the behaviour was found to be unsuccessful and a new strategy tried. Registered staff reported that the new strategy was effective while Personal Care Provider staff reported that the strategy was not effective. RPN #113 confirmed that registered staff had not assessed resident #029 when they were exhibiting the identified behaviours within at least the previous six months. RPN #113, RN #101 who was the Responsive Behaviour lead in the home, and the DOC confirmed that staff failed

to assess resident #029's resistance to care for triggers that may have caused the resident to demonstrate resistance to care over an identified time period of three months in 2017, and when there as a change in the identified trigger on an identified date. [s. 53. (4)] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 12, 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 : 009

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following are developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This Order is based on the application of the factors of severity (2), scope (3) and compliance history (3) in keeping with O. Reg. 79/10, s. 299. This is in

respect to the severity of potential for actual harm experienced by three residents, the scope widespread of incidents and the licensee's history of noncompliance that included non compliance in relation to related non compliance in O. Reg. 79/10, s. 53 (4) as follows: two Written Notifications (WNs) issued in May 2015 and April 2016, two Voluntary Plans of Correction (VPCs) issued in July 2016 and October 2016 and five Compliance Orders (COs) issued in May and November 2016, March 2017 and twice in May 2017.

2. The licensee failed to ensure that written approaches to care were developed to meet the needs of the residents with responsive behaviours that included screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

On July 25, 2017, Long Term Care Homes (LTC) Inspectors requested that the home provide policies that directed staff regarding care provided to residents with responsive behaviours. The home provided one policy as follows: The Residents with Special Needs "Responsive Behaviour Management" policy number 4.11.10, last reviewed May 2017. This policy directed staff about their role in the care of residents with "severe escalating" high risk responsive behaviours, such as residents who posed a significant risk to themselves, other residents, staff and /or visitors. The policy did not include written approaches to care for residents demonstrating other behaviours such as resistance to care, wandering, agitation, anxiety, in relation to screening protocols, assessments or reassessments and identification of behavioural triggers. This inspection revealed that residents #027, #028, and #029 had not been assessed or reassessed when they exhibited responsive behaviours that were not "severe escalating" high risk responsive behaviours according to Registered Nurse (RN) #101.

During interview, the Director of Care (DOC), Assistant DOC, and RN #101 who was the responsive behaviour lead in the home, reported that the Clinical Consultant hired by the licensee's delegated Management Company discarded many of the home's previous responsive behaviour policies. The Nurse Consultant confirmed that staff had access only to the above mentioned policy regarding "severe escalating" behaviours. The policy was reviewed with the Nurse Consultant, the DOC, ADOC and RN #101; they confirmed that the policy did not include written approaches to care that included screening protocols, assessment, reassessment or the identification for behavioural triggers that may

result in responsive behaviours. [s. 53. (1) 1.] (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 12, 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 : 010

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

Linked to Existing Order / Lien vers ordre existant:
2017_587129_0002, CO #006;
2017_555506_0012, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that, 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, that the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with.

The plan should be submitted via email no later than September 22, 2017, to Cathie Robitaille (LTC Inspector) 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. This order is based on the application of the factors of severity (2), scope (1) and compliance history (5) in keeping with O. Reg 79/10, s. 299. This is in respect to the severity of the potential for actual harm for the identified residents, the scope of isolated of incidents and the licensee's history of non-compliance that included: written notification (WN) issued March and August 2016 and voluntary plans of corrective action (VPCs) issued in February, May, June and November 2016 and two compliance orders (COs) issued in May 2017 and July 7, 2017.

2. The licensee failed to comply with compliance order #006 O. Reg. 79/10, s. 8(1)(b), inspection report #2017_587129_0002 (A1). The compliance order directed the licensee to comply with the following by July 14, 2017:

A) The licensee shall review and were necessary revise the following policies: Medication Errors, The Medication Pass, Administration of Medications and Treatments, Responsive Behaviour Management, Falls Prevention Program, and the Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes.

B) The licensee shall provide training to all staff responsible for complying with the directions contained in the above noted policies. Attendance records are to be maintained related to this training.

C) The licensee will develop and implement a system for monitoring staff's compliance with the directions contained in the above noted policy/procedure documents.

3. The licensee failed to comply with compliance order #001 O. Reg. 79/10, s. 8(1)(b), inspection report #2017_555506_0012. The compliance order directed the licensee to comply with the following by August 11, 2017:

A) The licensee shall review and where necessary revise the following policies: Preventative Skin Care Program, Feeding and Hydration Policy, Safe Handling and Assessing Policy, Disposal of Medication (Poured or Wasted) and Opioid Patch Disposal.

B) The licensee shall provide training to all staff responsible for complying with the directions contained in the above noted policies. Attendance records will need to be maintained related to this training.

C) The licensee will develop and implement a system for monitoring staff's compliance with the directions contained in the above noted policy/procedure documents.

4. The licensee failed to ensure that where the Act or this Regulation required 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 complied with.

A) In accordance with O. Reg. 79/10, s. 30(1) and 30(1) 1, the licensee was required to have an organized program for falls prevention and management that included relevant policy and procedures.

The licensee failed to ensure that staff complied with the licensee's policy and procedure located in the Resident Services Manual and identified as section 4.1 Resident Rights and Safety, subsection 4.1.12 Falls Prevention Program with a reviewed date of July 2017.

The licensee's procedure directed:
a) Following completion of a Falls Risk Assessment after any fall, staff were to develop interventions to address residents identified as high risk and implement an interdisciplinary plan of care.

The Director of Care (DOC), registered staff #111 and resident #021's clinical record confirmed that staff did not comply with the above noted direction when it was identified that the resident's risk of falling increased. A review of the resident's plan of care indicated that no new care interventions had been added to the resident's plan of care since before the fall and staff had not developed or implemented interventions to manage the identified increased risk of falling.

B) In accordance with s. 21., the licensee shall ensure that there were written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

The licensee failed to ensure that staff complied with the licensee's policy "Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes" identified as section 4.2, subsection 4.2.10, last revised in May 2017.

A review was completed of the eight (8) complaints received from the home's compliance date of July 14, until August 14, 2017 the last date a complaint was received by the home at the time of the inspection. The procedure within this policy directed as follows:

a) Every written or verbal complaint made to a staff member concerning the care

of a resident or operation of the home is dealt with as follows: 1d) The Administrator shall add the basic complaint information to the complaint log, then forward the complaint to the relevant Department Manager for investigation.

The Administrator did not comply with this direction when he acknowledged that the expectation is that the Administrator sign and date all of the complaint forms at the bottom of page one, before forwarding the complaint to the relevant Department Manager for investigation. A review completed with the Administrator of the ten logged complaints received identified, eight of ten of the home's suggestions, concerns and complaints forms had not been signed by the Administrator. The inspector also confirmed with the Administrator that four of the complaint forms had been signed by other staff members in the home.

b) Every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1g) A written response must be provided to the person making the complaint within 10 business days of the receipt of the complaint. For example:

Staff did not comply with this direction when the Administrator confirmed that providing a written response, applies to all written complaints however, not those the home can resolve before it becomes a written complaint. The Administrator then confirmed that the only complaints that had a written response, were those that were done through email as that was the complainant's choice of correspondence.

c) The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: 2d) The final resolution, if any.

Staff did not comply with this direction when the Administrator confirmed that two out of eight of the home's suggestions, concerns and complaints forms had no final resolution were one was required.

d) The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: 2e) Every date on which any response was provided to the complainant and a description of the response.

Staff did not comply with this direction when the Administrator confirmed that five

of eight of the home's suggestions, concerns and complaints forms were blank in regards to every date on which any response was provided to the complainant and a description of the response.

e) The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: 2f) Any response made in turn by the complainant.

Staff did not comply with this direction when the Administrator stated that they could not confirmed if complainants had responded and that six of eight of the home's suggestions. The section of the concerns and complaints forms where it indicated if a response was made by the complainant was left blank.

The Administrator also confirmed at the time of the interview with the inspector that he was utilizing the home's policy last reviewed March 2016 and that he had not received training on the May 2017 revised policy. [s. 8. (1) (a),s. 8. (1) (b)]
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 12, 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 14th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Theresa McMillan

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