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
Jan 9, 2018	2017_610633_0023	025066-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street P.O. Box 1600 WALKERTON ON N0G 2V0

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

BRUCELEA HAVEN LONG TERM CARE HOME - CORPORATION OF THE COUNTY OF BRUCE
41 McGIVERN STREET WEST P.O. BOX 1600 WALKERTON ON N0G 2V0

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

SHERRI COOK (633), ADAM CANN (634), INA REYNOLDS (524), NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 6-10, 14-17, 20-24, 2017.

The following inspections were conducted concurrently during this inspection:
Log #032577-16/IL-47974-LO- Complaint related to care.
Log #028448-16/M507-000019-16- Critical incident related to bathing, care, dining, housekeeping and equipment.

Log #032279-16/M507-0000025-16- Critical Incident related to falls.
Log #028733-16/IL46961-LO- Complaint related to alleged abuse, dining and staffing.
Log #028542-16/IL-46949-LO- Complaint related to dining, responsive behaviours and staffing.
Log #006080-17/IL-49926-LO- Complaint related to staffing.
Log #018374-17/IL-52279-LO- Complaint related to staffing, bathing and dining.
Log #012899-17/IL-51477-LO- Complaint related to medications.
Log #'s 006980-17, #010109-17 and #032577-16/HLTC2966MC-2017-4673- Complaints related to restraints and dining and snack service.
Log #'s 011168-17, #009842-17 and #003997-17/HLTC2966MC-2017-5049/HLTC2966MC-2017-4255/M507-000003-17- Complaints and Critical Incident related to alleged abuse, medication, call bells, pain management, staffing, food production, care and plan of care.
Log #017779-17/IL52195-LO- Complaint related to bathing and care.
Log #004253-17- Complaint related to falls.
Log #003716-17/M507-000002-17- Critical Incident related to falls.
Log #025461-17/IL-53935-LO- Complaint related to alleged abuse and infection control.
Log #'s #026146-17 and #027247/IL54120-LO/M507-000022-17- Complaint and Critical Incident related to alleged abuse/neglect.
Log #009205-17/M507-000022-17/M507-000008-17- Critical Incident related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Food Services Supervisor, the Recreation and Leisure Manager, the Administrative Assistant, Registered Nurses, a Dietitian, a Resident Assessment Instrument Coordinator, Registered Practical Nurses, Behavioural Supports Ontario Personal Support Worker, Personal Support Workers, Dietary Aides, Activation Aide, Ward Clerks, a Receptionist, a Housekeeper, a Co-op Student, a Residents' Council member, residents and family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of
care for identified residents were reviewed. Additionally, the inspector(s) observed medication administration and drug storage areas, resident/staff interactions,

infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **21 WN(s)**
- **14 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A Complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged abuse of multiple residents. The complainant also stated that there were no Critical Incident System (CIS) reports submitted by the home to the Director as required.

The home’s investigation records dated on specified dates included staff reports to the Director of Care (DOC) and the Administrator that an incident of alleged abuse occurred. The staff member continued to work in the home during the home's investigation and on a later specified date the staff member was provided education related to their approach.

In interviews with a specific PSW and Registered Practical Nurse (RPN) on specific dates they said they spoke with the identified resident and the staff agreed that the incident of abuse by the PSW towards the identified resident occurred. One RPN said that they had reported the PSW in the past.

In an interview with the identified resident, months after the alleged incident, they recalled the incident of abuse by the identified PSW.

In an interview with the identified PSW on a specific date they said that the incident was a misunderstanding.

In interviews with PSW's and RPN’s on specific dates, they said that the incident was considered abuse.

When the DOC was asked, in an interview on a specific date, what they considered to be abuse they responded "according to the definitions in the abuse policy”. The home's abuse policy defined the incident as abuse.

In an interview with Director of Care (DOC) on a specific date they stated that they felt like they failed the resident.

The licensee has failed to ensure that an identified resident was protected from abuse by an identified PSW on a specific date.

2. The home’s investigation records related to another resident stated that the resident complained about this specific staff member being too abrupt and rough and the staff

member would not listen to them. The resident also stated that they had problems with this staff member before. The investigation records included statements by the resident, their family member and staff that the incident occurred and the issue had been discussed in the past. The staff member was not off work pending the investigation completed by the DOC.

In an interview with a specific PSW on a specific date they said that they witnessed the identified staff member being very rough with the identified resident and they had told the staff member to stop and they did not listen. This PSW informed an RPN of their concern and was very upset and uncomfortable with what they saw.

In an interview with an RPN on a specific date they said that the resident told them that the identified PSW was too rough and they did not want them to do their care. The RPN also stated that the PSW had reported to them and this PSW was visibly concerned.

In an interview with the identified resident and their family member on a specific date, they said that the identified PSW was very rough with their care and they had told the staff that they were hurting them and they did not stop. The resident also stated that the PSW did not listen to them. The resident's family member said that the resident does not usually complain and they had spoken about the incident for days after.

In an interview with the identified PSW on a specific date they agreed that the resident did not want them to do their care and denied being rough while providing care.

In an investigation note by the DOC and findings interview note with the DOC, Administrator and PSW on a specific date it was stated that there was a need for a gentler approach by the identified PSW.

In an interview with DOC and Administrator on a specific date, the DOC stated that they investigated the incident and thought that the PSW was not intentionally being rough. The DOC said that they had provided the PSW teaching related to their approach. The PSW was not off work pending the investigation completed by the DOC.

The licensee has failed to protect an identified resident from abuse by an identified PSW on a specific date.

3. The home's investigation records included that an identified PSW did not provide specific care on specific dates.

In an interview with the identified resident they said that they recalled a recent incident that resulted in the resident waiting one to two hours for care. The resident stated that they were uncomfortable and never did receive this care from the identified PSW. The resident also said that they had this PSW in the past and this PSW would say that they would come and assist them and they did not.

A Critical Incident System (CIS) was submitted to the MOHLTC by the DOC on a earlier specific date that stated that the identified resident did not receive this specific care and the resident was able to identify the identified PSW at that time. This report was amended by the DOC later and stated that "upon review of the investigation notes the resident was not able to identify the staff directly". The DOC's investigation "determined that another PSW had not provided the resident care".

The home's investigation records did not include all relevant documentation and the PSW was not off work pending the investigation completed by the DOC.

In an interview with the identified PSW on a specific date they said that they recalled the incident however, they denied that the resident waited or was not provided care again by them on a specific date.

During interviews with a PSW and RPN's on specific dates they said that the incident was considered neglect.

The identified PSW received a written letter by the DOC on a specific later date that outlined a verbal warning that stated that the incident was considered abuse.

When the DOC was asked in an interview on a specific date what they considered to be neglect they responded "according to the definitions in the abuse policy. We also follow the MOH guidelines". The home's abuse policy stated that the incident was defined as neglect.

The licensee has failed to protect an identified resident from abuse by anyone and has failed to ensure that the identified resident was not neglected by staff on specific dates.

4. The home's investigation records stated that another identified resident had received a specific injury by a PSW and their family member was upset. Staff had reported the incident to the DOC on specific dates. The HCR for the resident documented that the

injury was present and the resident recalled the incident and the identified PSW staff member. The records included an interview with the identified PSW and they agreed that the incident occurred. The PSW was not off work pending the investigation completed by the DOC.

The HCR for the identified resident on specific dates by the DOC stated “investigation initiated- resident not able to recall what happened or what staff did; notes indicate that no abuse took place; etiology of injury unknown as the resident was agitated”.

In an interview with an RPN they stated that the resident had an injury on a specific location of their body. When the RPN was asked if they suspected that abuse may have occurred at the time they replied “yes”.

In an interview with the identified PSW on a specific date they said that they recalled the incident and described the actions they took at the time of the incident. The PSW explained that they did not see the injury at the time, agreed that the resident sustained an injury and they understood that this was considered abuse.

In an interview with the identified resident on a specific date they were unable to recall the incident.

In interviews with PSW’s and RPN’s on specific dates they said that the incident was defined as abuse.

When the DOC was asked in an interview on a specific date what they considered to be abuse they responded “according to the definitions in the abuse policy”. The home's abuse policy defined the incident as abuse.

In a "findings interview" completed by the DOC and notes taken by Administrator with the identified PSW on a specific date it was stated that the PSW needed to take a more gentle and less aggressive approach.

The PSW's employee file showed that a verbal warning and written warning had been given to the PSW related to resident approach and not following a resident's plan of care.

In an interview with the DOC on a specific date they said they investigated the incidents however, they did not believe they were intentional and were unable to substantiate at the time. The DOC stated that it was "more of an approach and they had provided the

PSW with teaching".

The licensee has failed to ensure that an identified resident was protected from abuse by the identified PSW on on a specific date.

The licensee has failed to protect three residents from abuse by anyone and failed to ensure that another resident was not neglected by the licensee or staff.

The severity of the issue was determined to be actual harm/risk, the scope of the issue was a pattern and the home had a history of unrelated noncompliance.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred was immediately reported with the suspicion and the information upon which it was based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

In a specific time period eight incidents related to the alleged abuse towards eight identified residents occurred and there were no Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care (MOHLTC) immediately and the MOHLTC after hours pager was not called when appropriate.

A Complaint was received by the MOHLTC on a specific date to inform the Director of the alleged abuse of multiple residents and that there were no CIS reports submitted by the home to the Director as required.

The home investigation records for the eight identified residents included incidents of alleged abuse.

In interviews with PSW's, Registered Practical Nurses (RPN's) and Registered Nurses (RN's) on specific dates they all said that they did not report alleged abuse to the Director as this was the role of the Director of Care (DOC).

When the DOC was asked in an interview on a specific date what they considered to be abuse/neglect they responded "according to the definitions in the abuse policy". They also follow the MOH guidelines". The DOC also stated they completed most if not all of the alleged abuse investigations and they were the lead for the Abuse Program in the home. The DOC explained that their role was to complete all the CIS reports and all the follow-up that included staff discipline and education and also with the family. When asked what was the process and expectation for staff related to reporting abuse in the home, the DOC replied that all staff are aware of what to do. The DOC explained that staff were to immediately contact the charge nurse as they were the leads on the floor and the charge nurse would contact them or the Administrator to receive further direction. The DOC also said that they or the Administrator would report to the Director by use of the Critical Incident System (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) and this would include the abuse incident and the investigation steps that were already taken. The DOC explained that the charge nurse would document the subjective comments of the resident and their objective observations at the time of the incident and this was usually by email but could also be written and directly if the DOC

was present in the home. The DOC also stated that when an incident occurred after hours, staff were expected to call the DOC or Administrator for direction. The DOC also stated that rarely was the MOHLTC after hours pager used and they had access to complete mandatory reporting from home. The DOC said that staff were to report alleged/actual abuse to them and they understood that the expectation was to report allegations of abuse/neglect to the Director immediately.

The home's abuse policy defined the eight incidents as abuse.

In an interview with the Administrator they said that the expectation for staff related to reporting alleged abuse was to email the DOC that would complete all the investigations and mandatory reporting to the Director. The Administrator also said that the DOC was the lead of the Abuse Program in the home. The Administrator stated that they do not submit CIS reports to the Director and if they were on call when the incident occurred they would contact the DOC.

In an interviews with the Administrator and DOC on specific dates they both said that they had some confusion about reporting to the MOHLTC. The DOC explained that they were investigating first to determine if abuse had occurred and needed to be sure of the allegation before reporting. The DOC explained that they felt that the incidents were not done intentionally. The DOC agreed that they should have completed CIS reports to the Director related to the the allegations of abuse towards the eight identified residents and they did not.

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

The severity of the issue was determined to be minimal risk, the scope of the issue was widespread and the home had a history of unrelated noncompliance.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The Licensee has failed to provide for a staffing mix that is consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation.

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

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, by the family member of an identified resident. The complaint was related

to regular bathing and hygiene.

An anonymous complaint was submitted to the MOHLTC on a specific date.
In an interview in Stage 1 of the Resident Quality Inspection (RQI) on a specific date, another resident stated that "when there is a shortage of staff, I will miss my bath. I missed it about two weeks ago."

In another interview in Stage 1 of the RQI on a specific date, another identified resident stated they had to fight to get their bath. The resident explained that it caused stress to them when the bath staff did not come to work that day as they worried about getting their bath. The resident also said related to bathing that "it was bad for those residents that can't speak for themselves".

In an interview by another inspector on a specific date with another identified resident they said that they had concerns about missing their baths. The resident stated that they often missed their baths on a specific date and there were three occasions that they were not offered another bath. The resident stated that there were two Personal Support Worker's (PSW's) per floor, with one bath PSW that worked between the two wings on the floor. The resident also said that if the floor was short, it was the bath PSW that was pulled to work the floor rather than to administer the resident baths. In an interview with a Registered Practical Nurse (RPN) on a specific date they stated that this resident tracked their missed baths and they had missed five out of seven of their baths recently.

The plan of care for another identified resident was reviewed in Stage 2 of the RQI by another inspector related to other complaints that were received by the MOHLTC on specific dates. The complainant stated concerns with staffing shortages in the home. The resident did not receive their bath within a specific time period and the family had requested that the resident have a bath.

During interviews with the Ward Clerks on a specific date they said that the normal staffing levels in the home were three PSW day bath shifts, 13 PSW day shifts and 12 PSW evening shifts in total with one evening bath shift and six night PSW shifts. The Ward Clerks also said that on Monday and Friday there was an extra four hour bath shift and there was also a new full time float PSW that would help wherever needed. They further explained that there were two PSW's on each team (unit) and the one bathing staff was shared between each floor of 48 residents. The Ward Clerks also said that the secure unit had an extra PSW on days and for evenings there were two PSW's per team on every unit and one evening bath PSW that floats throughout the whole home. The

Ward Clerks also explained that when staff calls in they tried to call a staff to work for the same day or the next day in order to cover the missed baths. One Ward Clerk stated that the floors would call them to let them know who missed their baths and that there was no official documentation for tracking missed baths. Both Ward Clerks stated that the weekends were the worst for staffing and agreed that there have been residents lately that have missed their baths.

During an interview with the Director of Care (DOC) on a specific date they stated that there were 144 resident in the home with 24 residents on each resident home area (RHA). The DOC also said that the full Personal Support Worker (PSW) staffing levels in the home for days/evenings were two PSW's on each team/resident home area (RHA) with one bathing staff shared between each floor. The secure unit had an extra PSW on days and there was one evening bath PSW that floated throughout the whole home. The DOC also said that there was a new PSW float position that was implemented in September of this year and this PSW would go to where the needs of the residents were including baths. The DOC explained that a new process, "Bathing Algorithm" was also implemented in September of this year for tracking missed baths and was to be followed when working short staffed and in addition, the Ward Clerk would document the missed baths in the "bath binder". The DOC stated that the expectation for documentation related to missed baths included refusal and resident unavailable was to be completed by the PSW's in Point of Care (POC) and the PSW's were to also document "activity did not occur" in POC if a resident missed their bath on their scheduled day. The DOC also stated that missed baths would be also documented on the bathing lists contained in the "bathing binder" kept by the Ward Clerk. The DOC stated that they would expect to see a missed bath documented in both places.

The home's policy "Nursing-Staffing" it was noted that there was a provision for the organization of shifts and it included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work. The home's 2017 annual staffing evaluation was completed by the DOC and Ward Clerk and committee members on a specific date for a specific period. Under the sub-heading "Goals & Objectives for Period under Review" the following was documented:

1. "To have 100% continued bath coverage".
a. "When working short bath person is last to be pulled".
b. "Try to backfill the next day or the same day".

2. "To have 100% complement of staff".

Under the sub heading "Summary of Changes Made/Accomplishments" it was documented that "daily meeting in the fall and early winter to ensure baths are being done".

The home's action plan stated that items that required action included "ensuring residents were bathed twice a week by the method of their choice". The action plan included "hiring four PSW's, reviewing bathing daily, that all resident baths would be reviewed for resident preference, consistency with staffing with new schedules in January 2017 and assistance with help from the BSO staff, Ward Clerk, ADOC/RAI, program staff and environmental staff". Long-term goals included "reviewing bath lists, baths shifts and the number of baths on each shift when working short". The completed date was "on-going and January 2017".

In an interview with a PSW by another inspector on specific date they said that there were 24 residents on their unit to care for. They also stated that there are two PSW's during the day shift and one bath staff floats from side to side between the units. The PSW also stated that they work short on weekends and lately they have been working short the majority of their shifts. The PSW further explained that the bath person often would get pulled and from the unit and would be put where the shortage of staffing was. The PSW also said that baths are being missed because of the shortage of PSW staff in the home.

In an interview with another PSW on a specific date they said that they do not do bath shifts. The PSW also said that they have been short PSW staff quite frequently, residents were not receiving their baths twice weekly and a missed bath was documented as "activity did not occur" in POC. When asked how the shortage of PSW staff impacted resident care, the PSW replied that "baths are missed, care takes longer, and residents are not washed as good as with a bath. When working short, staff would do a bed bath instead". The PSW explained that the residents "don't get the good clean".

In an interview with another PSW on a specific date, they said that they have not done baths for a few years and the expectation was that a resident received a bath two times a week. The PSW stated that a missed bath was documented as "activity did not occur" in POC and they agreed that the home often ran short of staff. When asked how the shortage of PSW staff impacted resident care the PSW replied that "care takes longer, some residents just get the basic care, the basics that's it, it's not fair to the residents, they deserve better".

In an interview with a Registered Practical Nurse (RPN) on a specific date they said that the residents that have baths scheduled on the weekends would often miss their baths and that this was "a real issue". They also said that missed baths were not documented and that "many residents have missed their baths for days". The RPN explained that the residents were given a bed bath instead and stated that working short had become the "norm" as "every weekend we are short". The RPN also said that this has been going on since May of 2015. When asked how the shortage of PSW staff impacted resident care the RPN replied that it "impacts in every way. Everybody does their hardest, residents wait longer, eight out of my last ten shifts we were short staffed and it is not possible to get everything done". The RPN also stated that residents that were able to complain would get their baths before residents that can't speak for themselves.

In an interview with another RPN on a specific date they said that a staff had called in and the bath staff was called to work the floor. The RPN explained that residents would not receive their baths today unless someone stayed or came in. The RPN also said that the residents would not be given a bath or a shower today and a bed bath would be given instead. The RPN explained that a missed bath was "not recorded anywhere. It shows up as not done". The RPN also stated that "we are so short staff. I don't think we should be filling the empty beds. We do not have the staff to properly look after the residents". The RPN explained that there are 24 residents per unit with two PSW's, one nurse and a bath person for the floor if all the staff were here. The RPN further explained that one PSW had 12 residents and they had to provide care with several lifts on the unit that required two person assistance to transfer the residents. The RPN agreed that all residents did not get their baths twice a week.

In an interview with another PSW on a specific date they said that they were the bath float person, and the bath staff from the morning was pulled to the floor today. The PSW also said that the expectation was that residents were bathed twice a week and that it was "a staffing crisis right now, plain and simple". The PSW explained that when a resident didn't get a bath it was not charted and they had never charted under "activity did not occur" in POC. The PSW further explained that the residents today would get "am and pm care" and no bed bath would be given. The PSW stated that staffing had been short in the last year and there were many unfilled PSW lines and the PSW agreed that weekends were particularly short staffed. When asked how the shortage of PSW staff impacted resident care the PSW replied that there was not enough staff on the day shift to do the care that the residents needed even when they were not short staffed. The PSW agreed that all residents did not get their baths twice a week.

The plan of care for a three resident sample was selected for review related to bathing. The health care record (HCR) stated that these residents had missed their baths 12 percent of the time in a specific time period and "activity did not occur" was not documented consistently.

The Ward Clerks reviewed the HCR for the three identified residents and agreed that the residents missed their baths and there was no documentation completed by the PSW's that the bathing "activity did not occur".

The "bathing algorithm" as the process for tracking missed baths in the home, that was not dated, stated that the DOC "would be provided a list of resident names of who did not receive a bath/shower on their scheduled day".

A Ward Clerk reviewed the "bathing binder" and agreed that there was no documentation related to which residents missed baths and when this occurred within a specific period of time. The Ward Clerk also reviewed the paper PSW schedules and their computer documentation and stated the following related to PSW staffing on the specific dates that the three identified residents missed their baths:
-Short a full PSW staff for days, and short a night PSW from 0200 to 0600 hours, short one PSW staff on the 4th floor for a full shift.
-B4 short on the 4th floor- One full time PSW shift and did not have the bath shift PSW.
-No residents received their baths that day. No PSW bath shifts.
-Short four hours PSW bath, other staff stayed to complete other baths.
-Short 24 hours of bath shifts, called in the next day for 16 hours to make up the baths.
-Short 16 hours PSW staff.

The "PCC Facility Bulletin Board - Bruce County Homes - Brucelea Haven" on specific dates stated the following:
-Pull BSO to fill on 3 west, as we are short staff.
-Short staff on 3rd floor west side, bath PSW pulled to work the floor for today.
-Floor 4 is short on days today. RPN working both sides".

The staffing schedules for a specific period of time that were provided and calculated by a Ward Clerk on a specific date documented that on 22/46 days the home was without full complement of PSW's staff (48 percent) with one or more PSW shifts not filled on those days.

In an interview with the Administrator on a specific date they said that baths have been an issue lately and they had thought they were doing better but in the last three months they had slid back. The Administrator explained that they currently had 15 PSW lines not filled with some coverage from casual staff and that they were recruiting PSW staff constantly.

In an interviews with the Director of Care (DOC) on specific dates they said that the expectation was that all residents received a bath twice weekly by method of their preference and they agreed that the three identified residents had not. The DOC also agreed that when a resident bath was missed they would be offered a bed bath instead. The DOC also stated that the expectation was that the "bathing algorithm" and "bathing binder" for tracking missed baths in the home was followed by staff and they agreed that it had not been. The DOC also stated that the reason for the missed baths was that they were both short PSW staff and there were PSW staff that did not do bath shifts. The DOC stated that despite the action plan implemented in the home and the strategies for missed baths, residents were still not getting their baths as required. The DOC agreed that there was a process and documentation issue related to tracking resident's missed bathing and that this was in despite of what they had been working on over the past year. The DOC said that that monitoring and audits were not being completed related to tracking resident care and this included bathing.

The licensee has failed to provide for a staffing mix that is consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation including that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

The severity of the issue was determined to be minimal harm or potential for actual harm, the scope of the issue was a pattern and the home had a history of related noncompliance.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by licensee or staff or anything else provided for in the regulations, that the licensee knows of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident.

There were no CIS reports immediately submitted to the Director for eight incidents of alleged abuse to residents over a specific period of time. In addition, all investigations were not completed immediately and corrective action was not taken in response to each incident.

The home's investigation records showed alleged incidents of abuse that were reported to the DOC by residents and staff and the home did not take appropriate action in response to each incident. The staff member was not placed off work pending the investigations completed by the DOC and all signed statements from staff were not included. The staff member received a verbal and a written warning at a later date.

The home's abuse policy in effect at the time of the incidents, "Prevention of Abuse and

Neglect" stated that:
-"To ensure that every incident and suspicion of abuse is investigated, documented and reported".
-"The supervisor is expected to immediately send an employee away from the workplace pending a thorough investigation and decision regarding disciplinary action".
-"Documentation will be recorded as soon as possible after the abuse is reported".
- A written incident report would be completed that included written signed statements from all witnesses, resident status, assessment for injury and future prevention".
-"The Administration would notify the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident".
-"The resident and the resident's SDM, of any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon completion of the investigation".
-"Police shall be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence".
-"All cases of validated abuse will remain on the staff employment file".
-"All validated abuse will be issued disciplinary action in the form of progressive suspensions which are individually reviewed and issued".
-"Mandatory abuse prevention training is required to be completed during the time of the suspension and submitted prior to returning to work".

The employee file for the identified staff member did not include a record of all cases of validated abuse, progressive suspensions, which were individually reviewed and a record of mandatory abuse prevention training completed by the staff member while suspended and before returning to work. The employee file only included the two letters of suspension/disciplinary action on two later dates.

In an interview with the identified staff member on a specific date they said that were aware of the alleged incidents of abuse. The staff member clarified that they received two warnings, a verbal and written warning on the same day however, they had not received any abuse education related to any alleged incidents. The staff member also said that the only time they were off work was then. The staff member agreed that they caused an injury to two residents and they denied all other alleged incidents.

O. Reg. 79/10, s. 97 (1) states that "every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident".
O. Reg. 79/10, s. 97 (2) states that "the licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation".
O. Reg. 79/10, s. 98 states that "every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence".

In an interview with the DOC and Administrator on specific dates they said that they were not withholding information or critical incidents and they had some confusion related to reporting to the Director. The DOC said that they had investigated the alleged incidents and needed to be sure of the allegation before reporting to the Director. The DOC agreed that they did not submit any CIS reports or results of their investigations to the Director. The DOC also agreed that their investigations did not include all written statements from all witnesses at the time of the incidents and some interviews were missing dates. The DOC also agreed that they did not speak with the resident's Substitute Decision Maker (SDM)/Power of Attorney (POA) related to either the allegations of abuse or the results of their investigations and they also did not contact the police. The DOC explained that they had felt like the issue was more related to the approach while providing care and they had provided them with teaching related to their approach. The DOC said that they usually placed an employee off work with pay during their investigation and the staff member was only off pending the results of their investigation on a later date and they had received a verbal and written warning at that time.

In an interview with the Administrator on a specific date they said that there were only two times that the staff member was off and that was at a later date pending the results of their investigation and again on when the inspectors were present in the home. The Administrator also confirmed that the staff member resigned on a specific date.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by licensee or staff or anything else provided for in the regulations, that the licensee knows of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident.

The severity of the issue was determined to be minimal risk, the scope of the issue was widespread and the home had a history of unrelated noncompliance.

2. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The home did not report to the Director the results of every investigation and every action taken related to eight incidents of alleged abuse/neglect that occurred during a specific time period.

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

i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

The home's investigation records related to the alleged abuse/neglect of the eight identified residents included interviews by the Director of Care (DOC) with the residents, some family members and some interviews and meetings with staff. The investigation records also document meetings with the staff member and DOC and the Administrator. The home's investigation records did not include written incident reports and signed statements of all witnesses and in some cases the dates of the interviews were missing. The investigation records also did not include whether a physician or registered nurse in the extended class was contacted, what other authorities were contacted, whether a family member, person of importance or a substitute decision-maker of any resident involved in the incidents was contacted and the name of such person or persons, appropriate actions taken in response to each incident, the outcome or current status of the individual or individuals who were involved in the incident and the long-term actions planned to correct the situation and prevent recurrence.

In an investigation note dated titled "Complaints/Investigations" stated that the DOC reviewed the staff member's approach on specific dates.

The staff member also received a written letters by the DOC on specific dates that outlined a verbal and written warning. The PSW was off working pending the DOC's investigation at a later date and was required to review the home's whistleblower policy.

In interviews with the Administrator and DOC on specific dates they both said that they had some confusion about reporting to the MOHLTC. The DOC explained that they were investigating first to determine if abuse had occurred and needed to be sure of the allegation before reporting to the Director. The DOC explained that when they had investigated the staff member related to all allegations of abuse/neglect that were received by residents and staff they had thought that the staff member's actions were not intentional and they had provided them teaching related to their approach. The DOC agreed that they should have completed CIS reports and submitted the results of their investigations to the Director related to the allegations of abuse towards the eight identified residents and they did not.

The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The severity of the issue was determined to be minimal risk, the scope of the issue was widespread and the home had a history of unrelated noncompliance.

Additional Required Actions:

CO # - 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged abuse of multiple residents

The home's investigation records showed that on a specific date a Registered Practical Nurse (RPN) had received a report of an allegation of abuse from a Personal Support Worker (PSW) who was told by an identified resident that they were concerned with who was working because of a specific incident that had occurred that alleged the resident was not treated with dignity and respect.

In an interview with a PSW on a specific date they said that they defined the incident as abuse and they felt that the resident was genuine in their concern.

In an interview with a RPN on a specific date they said that they spoke to the identified resident who told them that they did not want to have care from the identified PSW. The RPN also said that they had reported the resident’s concern to the DOC as they thought that it was possible that verbal abuse may have occurred.

In an interview with the resident on a specific date they said that they recalled the incident and verified that an incident occurred in which they were not treated with dignity and respect.The resident also said that they have received care from the identified PSW since this incident and they had no further concerns with this staff member.

In an interview with the identified PSW on a specific date they denied the incident.

2. The home’s investigation records included staff reports from another resident that they felt threatened and afraid of the PSW related to a specific incident. The resident reported they had difficulty sleeping after the incident.

In interviews with PSW's on specific dates they said that the resident was genuine and scared. One PSW stated that they felt that they needed to report the incident as the resident trusted them.

In an interview with the resident on a specific date they said that the care in the home was not good and they did not want to talk about it.

In an interview with the identified PSW on a specific date they denied the incident.

In a findings interview note by the DOC with the Administrator taking notes on a specific date it was stated that it had come up a few times that residents had said that the identified staff member had advised them to not carry out a specific action however, this was not the home's expectation.

The staff member received a written letter by the DOC on a specific date that outlined a verbal warning that included to stop informing residents of a specific action. This letter also stated that “this is a violation of their rights and considered emotional abuse”.

The licensee has failed to fully respect and promote two identified resident's rights to be

treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's have a right to be treated with courtesy and respect in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

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

Findings/Faits saillants :

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

An identified resident had a specific diagnosis and was administered a medication that required laboratory (lab) monitoring.

The plan of care stated that the resident was to have lab monitoring. This lab work was ordered by the Physician to ensure that the schedule lab work was completed on the requisition. Any abnormal lab results or symptoms were to be reported to the Physician.

The Physician order on a specific dated stated that lab work was to be completed at specific times and the Physician wanted this order renewed.

Two labs were not completed for the identified resident in a specific time period.

The home received a written complaint from the Substitute Decision Maker (SDM) of the identified resident. The SDM stated that the resident's lab was checked and the medication was not within the therapeutic range.

On a specific date the Inspector reviewed the lab that was completed by the home with the DOC and they agreed that the lab monitoring should have been completed as ordered and was not.

The DOC told another inspector on a specific date that the expectation would be that if a lab was missed or when the resident refused, the lab would be repeated the following week .The DOC explained that the requisition would be put back in the binder to alert staff to reproach the resident to complete the lab work that week.

The licensee has failed to ensure the care set out in the plan of care related to an identified resident's lab monitoring was provided to the resident as specified in their plan.

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one Registered Nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.

Complaints were received by the Ministry of Health and Long-Term Care (MOHLTC) related to 24/7 Registered Nurse coverage. The complainant stated that there was not a Registered Nurse (RN) working in the home on a specific date and on numerous other night shifts.

The registered staff schedules for a specific period of time stated that there was not a RN employed by the home as a regular employee on shift for 9/14 night shifts (64 percent) as well as on one day shift (1 percent). The registered other staff schedules for a specific period of time stated that there was not a RN employed by the home as a regular employee on 13/28 night shifts (46 percent).

In an interview with the Director of Care (DOC) on a specific date they stated that the home has had difficulty staffing RN's in the home and it was the homes expectation that a RN who works for the home was in the building at all times. The DOC reviewed the schedules and stated that agency RN's had been working in the building on the nine night shifts reviewed. The DOC also said that for the one day shift, there was not a RN working in the building at all. The DOC also stated that an agency RN had been working on all 13 night shifts during another specific time frame.

The licensee has failed to ensure that at least one Registered Nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times.

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with all applicable requirements under the Act.

O. Reg. 79/10, s. 31 states that "this section and sections 32 to 47 apply to,
(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and
(b) the organized program of personal support services required under clause 8 (1) (b) of the Act".

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

Five policies related to bathing were provided by the Director of Care (DOC).The DOC stated that these were the policies related to Personal Support Worker's (PSW's) bathing residents in the home. The home's bathing policies did not reflect the legislative requirements as stated in O. Reg. 79/10, s. 33 and stated the following:
1. "Complete Bed Bath" had an effective date of September 1991.
2. "Supervising Residents During Bathing" had an effective date of March 26, 2003.

3. "Bathing Schedule" had an effective date of June 17, 2003. This policy stated that "all residents will receive a bath/shower at least weekly, if required extra baths will be assigned appropriately and "residents requiring a regularly scheduled second bath per week will be arranged 3-4 days after their first scheduled bath."
4. "Giving a Shower" had an effective date of June 23, 2003.
5. "Tub Bath" had an effective date of June 23, 2003, and stated that "a tub bath would be completed at least once a week and more often if deemed necessary, or if the resident wishes."

The DOC agreed that the expectation was that residents received bathing two times a week by the method of their preference and also stated that these policies were old and outdated and needed to be reviewed and updated.

The licensee has failed to ensure that the home's policies related to bathing residents were in compliance with all applicable requirements under the Act.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation 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 is in compliance with all applicable requirements under the Act, to be implemented voluntarily.

WN #9: 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. (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 has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:

(d) contained an explanation of the duty under section 24 of the Act to make mandatory reports;
(e) contained clear procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

Eight incidents related to the alleged abuse of residents occurred and there were no Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the Director of Care (DOC) immediately and the MOHLTC after hours pager was not called when appropriate.

The Administrator provided the home's policy on a specific date and they said that this was the policy in effect previous to the new current policy in the home that was newly implemented. This policy was in effect at the time of the reported incidents of alleged

abuse towards the eight identified resident`s that occurred within a specific time period and stated that:

- "Step 3 Intervention to Stop Abuse: each employee must immediately report to their Supervisor, Charge Nurse, DOC or Administrator and the "MOHLTC decision tree appendix shall be used as a guide in determining reporting criteria".
-"Internal Notification by charge RN: The charge nurse will determine if there are reasonable grounds to suspect that abuse has occurred and initiate the initial investigations. If reasonable grounds exist the charge nurse shall report to Administration immediately, call designate at home if after hours that have any possibility to be grounded. Allegations that have not been founded to have the possibility to be grounded are reported to Administration same day if available, along with initiate investigation notes. If after business hours report shall be left for review of Administration on the next business day".
- "All staff interviewed were to write and sign statements" and these "shall be retained on file".
-"The supervisor to whom the abuse was reported to should prepare a written incident report that contained who was involved, written signed statements from all witnesses, what was observed, when the incident happened, any related events leading up to the incident and the status which included the impact of the abuse, assessment for injury and any treatments required, follow-up assessments" and "future prevention was to be included by documenting their opinion of ways the event could have been prevented".
-"External notification by Administration to MOHLTC: applicable reporting of abuse decision trees from the MOHLTC would be used to determine the reporting criteria and time frames via after hours contact and CIS".
-It was the "responsibility of management to ensure that a thorough investigation was completed and acted on in accordance with the Investigation of Allegation of Abuse policy".

The home's policy was unclear about timing, process, responsibilities, and obligations for reporting when reasonable grounds to suspect abuse, neglect or any of the other situations listed in LTCHA s. 24(1) were raised and did not contain an explanation of the duty under section 24 to make mandatory reports.

In an interviews with RPN's on specific dates they said that they did not complete initial investigations or obtain written statements, call the after-hours pager or completed CIS reports to the MOHLTC as their role was to report to the DOC.

In an interview with a Registered Nurse (RN) on a specific date they said that they did not speak to the resident directly as their role was to inform the DOC of the resident's report to the PSW. The RN also stated that the DOC would handle the investigation and follow-up. The RN said that the DOC was responsible to complete the mandatory reporting to the Director.

In an interview with the DOC on a specific date they stated they completed most if not all of the alleged abuse investigations and they were the lead for the Abuse Program in the home. The DOC said that their role was to complete all the critical incidents and all the follow-up that included staff discipline and education and also with the family. When asked what was the process and expectation for staff related to reporting abuse in the home, the DOC replied that all staff are aware of what to do. The DOC explained that staff were to immediately contact the charge nurse as they were the leads on the floor and the charge nurse would contact the them or the Administrator to receive further direction. The DOC also said that they or the Administrator would report by use of the Critical Incident System (CIS) to the MOHLTC and this would include the abuse incident and the investigation steps that were already taken. The DOC explained that the charge nurse would document the subjective comments of the resident and their objective observations at the time of the incident and this was usually sent to them in an email but could also be written and directly if they were present in the home. The DOC stated that when after hours, staff were expected to call the DOC or Administrator for direction. The DOC stated that rarely was the MOH after hours pager used and they had access to complete mandatory reporting from home. When asked if the current abuse policy included clear directions for staff related to the reporting process and mandatory reporting to the Director, the DOC replied "yes there is clear direction for staff contained in the policy. Their direction is to call me".

In an interview with the Administrator on a specific date they said that the expectation for staff related to reporting alleged abuse was to email the DOC who completed all the mandatory reporting to the Director. The Administrator also said that the DOC was the lead and that they do not submit CIS. The DOC and Administrator explained that the investigations and CIS reporting to the Director was completed by the DOC for consistency.

In an interview with the Administrator and on a specific date they both said that they had some confusion about reporting to the Ministry of Health and Long-Term Care (MOHLTC). The DOC explained that before reporting to the Director, they were investigating first to determine if abuse had occurred as they needed to be sure that

abuse had occurred before reporting to the Director.

In an interview with the Administrator on a specific date they stated that the home had just completed the implementation of a new abuse policy this year.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:

(d) contained an explanation of the duty under section 24 of the Act to make mandatory reports;
(e) contained clear procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy to promote zero tolerance of abuse and neglect of residents:

(d) contains an explanation of the duty under section 24 of the Act to make mandatory reports;
(e) contains clear procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the family member of a resident. The complainant stated that resident’s, face was not washed and the resident was not bathed regularly.

The health care record (HCR) stated that the resident was no longer at the home and was totally dependent on staff for all care. The resident required two staff assistance for bathing with the use of a mechanical lift and the care plan in PCC stated that the resident preferred a tub bath.

Point of Care (POC) tasks in PCC for a specific time period and the home's bathing schedule stated that the resident was scheduled for bathing twice a week and they had missed 3/26 baths (12 percent).

2. In an interview in Stage 1 of the Resident Quality Inspection (RQI) on a specific date another resident stated they had to fight to get their bath. The resident explained that it caused them stress when the bath staff did not come to work that day as they worried about getting their bath. The resident also said that “it was bad for those residents that can't speak for themselves”.

The HCR stated that the resident relied on one or two staff for all care and required one staff for total assistance for bathing. The care plan in PCC stated that resident they preferred a tub bath. The HCR and the bathing schedule stated that the resident was scheduled for bathing on twice a week and the resident had missed 3/26 baths (12 percent).

3. In another interview in Stage 1 of the RQI on a specific date another resident stated “when there is a shortage of staff, I will miss my bath. I missed it about two weeks ago.”

The HCR stated that the resident relied on one or two staff for all care. The resident required a mechanical lift and one staff physical assistance for bathing. The HCR stated that the resident preferred a tub bath. The HCR and the bathing schedule stated that the resident was scheduled for bathing twice a week and the resident had missed 3/26 baths (12 percent).

In interviews with Personal Support Worker's PSW's, Registered Practical Nurse's (RPN's) and the Assistant Director of Care (ADOC) on specific dates they all said that the expectation was that the residents received bathing two times weekly. These staff also said that the residents were not receiving their baths related to a shortage of staff in the home.

Ward Clerks reviewed the HCR for the three identified residents and agreed that the three residents missed their baths and there was no documentation completed by the PSW's that any type of bathing had occurred.

In an interview with the DOC on a specific date they said that resident preference for bathing was assessed on admission and if a resident missed their bath they would be offered a bed bath instead. The DOC further stated that the expectation was that all residents receive bathing by their method of preference two times weekly. The DOC reviewed the documentation for bathing for the three identified residents and agreed that the residents did not receive their baths twice weekly.

The licensee has failed to ensure that three identified residents were bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

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 residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of alleged abuse.

The home's investigation records stated that on a specific date the PSW transferred the identified resident alone when the resident required two person assistance, and the resident sustained an injury. The investigation records also stated, in an interview with the Director of Care (DOC) that the PSW stated that they were transferring the resident alone and the resident sustained an injury. The investigation records also stated in interviews with two PSW staff that were working with the identified PSW that they witnessed the PSW transferring the resident alone. They said that it took three PSW staff to help the resident to safety.

Risk Management in PointClickCare (PCC) on a specific date stated that the resident had altered skin integrity on a specific area as a result of the transfer.

The Minimum Data Set (MDS) and Care Plan in PCC stated that the resident required extensive assistance of two staff for a specific care.

In an interview with the identified PSW on a specific date they said that they recalled assisting the resident alone and the resident was injured while they provided care. The PSW also said that resident required two staff when transferring.

In an interview with the Administrator and DOC on a specific date they stated that the resident required two staff for transfers and agreed that the resident was injured from an unsafe transfer by the identified PSW on a specific date.

The licensee has failed to ensure that staff used safe transferring techniques when an identified resident was assisted by the identified PSW on a specific date,

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 staff uses safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident requiring end-of-life care receive care in a manner that met their needs.

On a specific date a Physicians order was obtained for active palliation that stated that an identified resident was having specific symptoms and they were to receive specific care. There was no completed pain assessment instrument completed with this change in the resident's condition.

The progress notes in PointClickCare (PCC) stated that a Registered Nurse (RN) reviewed the palliative orders on a specific date documented that an intervention for comfort. On two occasions the family of the resident asked if the intervention could be initiated however on both occasions it was not.

The homes Palliative Care Overview Policy dated stated in part:
-Provide exemplary palliative care, reflective of best practices.
-Provide pain and symptom management
-Palliative performance scale (PPS) "best fit" for the resident and assign a PPS score.

On a specific date the progress notes stated that the resident had declined and the comfort measure was provided as the resident was experiencing specific symptoms. The Physician's order for palliative care was not completed until three days later. The progress notes further stated that the family had concerns.

A review of the Point of Care (POC) documentation did not reflect the palliative care orders received on a specific date. The interventions in POC were not updated until later with a specific intervention.

On a specific date the Director of Care (DOC) said that the palliative interventions would go into POC to alert the PSW's and they would need to sign off on that care provided. The DOC further said that the Physician orders for the active palliation becomes the active plan of care for all staff to implement and follow.

The licensee has failed to ensure that the an identified resident, that required end-of-life care, received care in a manner that met their needs.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident requiring end-of-life care receive care in a manner that meets their needs, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The health care record (HCR) stated that an identified resident had specific diagnoses and was experiencing pain on specific dates.

The licensee's policy "Pain Management Program" stated in part that the home "shall ensure that when a resident pain is not relieved by initial interventions, the resident was assessed with using a clinically appropriate assessment instrument" and the MDS quarterly assessment, if the resident was experiencing moderate or severe pain, pain tool assessment would be completed.

The plan of care for the resident showed that a pain assessment tool was to be initiated to screen for uncontrolled pain and to reassess analgesic effect. The quarterly MDS section "J" that was completed in PCC on a specific date stated that the resident was experiencing pain "less then daily" and at times the pain was "horrible" and "excruciating".

The last documented completed pain assessment using a clinically appropriate assessment tool was on a specific date and showed that the resident had a pain assessment completed for uncontrolled daily pain and that "during this assessment the resident indicated current pain level was "nine out of ten" and a screening tool that was for Neuropathic Pain scored "three out of five indicators". There was no current pain assessment completed in PCC or in the resident's paper HCR.

During an interview with the DOC they said that the resident did not have a completed pain assessment completed using a clinically appropriate assessment tool in the PCC, the HCR or Risk Management. The DOC also said that there should have been a current assessment for the resident for pain when the resident was experiencing pain using a clinically appropriate assessment tool and there was not.

2. Another resident's plan of care stated that the resident had a change in condition related to pain and that the resident was to receive palliative care that included pain management.

A fax was sent to the Physician from the home that showed the the resident had been experiencing "mild pain four out of seven days" and the Physician ordered an intervention. There was no completed pain assessment instrument completed with this change in the resident's condition.

A Dietary Nutritional Assessment was completed on a specific date with a recommendation for nutrition to be comfort measures only.

The HCR stated that the resident was compliant with the intervention but had a specific symptom.

On a specific date a Physicians order was obtained for active palliation that stated that the resident was experiencing specific symptoms and an intervention was to be provided. There was no completed pain assessment instrument completed with this change.

On another specific date there was no completed pain assessment instrument completed with a change in the resident's condition.

In an interview with the the DOC on a specific date they said that the RN did not deny the resident the intervention and the context was more that they were providing health

teaching. The DOC further stated that there were no pain assessment completed for the resident.

The license had failed to ensure that if the resident's pain was not relieved by initial interventions, two identified resident's were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The home's investigation records provided by the Director of Care (DOC) stated eight incidents related to the alleged abuse/neglect towards were investigated by the DOC and four substitute decision-makers (SDM) /Power of Attorney (POA) were not notified of the incidents.

The home's investigation records and the progress notes in PointClickCare (PCC) did not include documentation that resident's SDM/POA) were notified of the alleged incidents.

The home's policy "Prevention of Abuse and Neglect" revised July 2012-April 2014, was in effect when the incidents occurred and stated that "the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident".

In an interview with the DOC on a specific date they stated they completed most, if not all, of the alleged abuse investigations and they were the lead for the Abuse Program in the home. The DOC said that their role was to complete all the Critical Incident System (CIS) reports to the Director and all the follow-up that included with the family. The DOC also stated that they investigated all the allegations of abuse towards the identified residents and they agreed that they did not speak with residents SDM/POA related to the allegation of abuse/neglect.

The licensee has failed to ensure that four resident's substitute decision-maker, if any,

and any other person specified by the resident, (a) were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

2. The licensee has failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The home's investigation records provided by the Director of Care (DOC) stated eight incidents related to the alleged abuse/neglect were investigated by the DOC and five substitute decision-makers (SDM) /Power of Attorney (POA) were not notified of the results of their investigation.

The progress notes in PointClickCare (PCC) did not include documentation that the identified resident's SDM/POA were notified of the results of the investigation completed by the DOC.

The home's abuse policy in effect at the time of the incidents, "Prevention of Abuse and Neglect" stated that "the resident and the resident's SDM, of any, are notified of the results of the investigation required under subsection 23(1) of the Act, "immediately upon completion of the investigation".

In an interview with the DOC on a specific date they stated they completed most, if not all, of the alleged abuse investigations and they were the lead for the abuse program in the home. The DOC said that their role was to complete all the follow-up that included with the family. The DOC stated that they investigated the allegations of abuse and agreed that they did not speak with the residents SDM/POA related to the results of the allegations of abuse/neglect investigations.

The licensee has failed to ensure that five identified resident's substitute decision-maker were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

The home's investigation records dated on specified dates included staff reports to the Director of Care (DOC) and the Administrator that an incident of alleged abuse towards the identified resident occurred. The investigation records do not include that police were notified of a specific alleged incident.

In an interviews with a specific PSW and Registered Practical Nurse (RPN) on specific dates they said they spoke with the identified resident and the staff agreed that the incident of abuse towards the identified resident occurred. One RPN said that they had reported the staff member in the past.

In an interview with the identified resident, months after the alleged incident, they recalled the incident of abuse by the identified PSW.

The progress notes in PointClickCare (PCC) for the identified resident did not include

documentation that the police were notified.

2. The home's investigation records stated that another identified resident had received a specific injury and their family member was upset. Staff had reported the incident to the DOC on specific dates. The HCR for the resident documented that the injury was present and the resident recalled the incident and the identified staff member. The records included an interview with the identified staff member and they agreed that the incident occurred. The investigation records do not include that police were notified of the alleged incident.

The progress notes in PCC for the identified resident do not include that police were notified of the alleged incident.

The home's abuse policy in effect at the time of the incidents, "Prevention of Abuse and Neglect" stated that "police shall be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence."

In an interview with the Director of Care (DOC) on a specific date they stated that they investigated the allegations of abuse and they agreed that they did not notify the police. The DOC explained that they needed to be sure that abuse had occurred and were completing investigations to substantiate that abuse had occurred before reporting.

The licensee has failed to ensure that the appropriate police force was immediately notified of the alleged incident of abuse of two identified residents that may have constituted a criminal offence.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) were considered in the evaluation;
(d) that the changes and improvements under clause (b) were promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to

inform the Director of alleged abuse.

Eight incidents related to the alleged abuse towards eight resident's occurred during a specific time period and there were no Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care (MOHLTC) immediately, the MOHLTC after hours pager was not called when appropriate, investigations were not completed per the home's policy and the families and the police were not notified when required.

The home's abuse policy in effect at the time of the incidents, "Prevention of Abuse and Neglect" stated that:

-"To ensure that every incident and suspicion of abuse is investigated, documented and reported".
-"An analysis of every incident of abuse or neglect of a resident is undertaken and the results are considered in the annual evaluation of the Prevention of Abuse & Neglect Program".
-"At least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes are improvements are required to prevent further occurrences".
-"A written record of the evaluation and changes implemented, including the date, names of person who participated and the date the changes were implemented is completed".

The "Prevention of Abuse and Neglect Program" provided by the Administrator on a specific date, stated that a program evaluation would be completed on an annual basis. It also stated that the effectiveness of the program would be evaluated and a written record would be kept of the names of the participants and summary of any changes made.

In an interview with the Administrator on a specific date they stated that the home had just completed the implementation of a new abuse policy this year and the Abuse policy and program evaluation had not been completed yet and was scheduled for December of this year. When the Administrator was asked for the previous Abuse policy evaluation for the year 2016, they stated that they were unable to locate any written evaluations for the years 2015 or 2016.

The licensee has failed to ensure
(a) that an analysis of every incident of abuse or neglect of a resident at the home was undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation was made to determine the

effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) was considered in the evaluation;
(d) that the changes and improvements under clause (b) were promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared.

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
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements are implemented is promptly prepared, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) the documented record (of complaints received) was reviewed and analyzed for trends, at least quarterly (b) the results of the review and analysis are taken into account in determining what improvements are required in the home, and (c) a written record is kept of each review and of the improvements made in response.

The complaint binder provided by Director of Care (DOC) was reviewed on a specific date.The records that were to be kept as complaints were not kept, were not being reviewed, and trends were not being analyzed at least quarterly.

In an interview with the Administrator on a specific date they stated that complaints were followed up by the DOC and some of the records were in their personal notebooks from meetings with families. The Administrator further stated that a quarterly review had not occurred for analysis and trending and the Administrator was uncertain if there ever was a quarterly review completed related to complaints received in the home.

The licensee has failed to ensure that the documented record was reviewed and analyzed for trends, at least quarterly, the results of the review and analysis were taken into account in determining what improvements were required in the home and a written record was kept of each review and of the improvements made in response.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (a) the documented record (of complaints received) was reviewed and analyzed for trends, at least quarterly (b) the results of the review and analysis are taken into account in determining what improvements are required in the home, and (c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a copy of the written complaint that was received relating to a matter that the licensee reports (or reported) to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant.

1) A record review showed that an identified resident was sent to the hospital related to uncontrolled symptoms.

A written complaint was received by the home from the resident's Substitute Decision Maker (SDM) related to care concerns. There was no date on the written complaint. There was an email response provided to the SDM on a specific date from the DOC that addressed a few of their concerns. In another email from the SDM to the DOC on a specific date the SDM further described more concern with care that had been observed by the SDM and there was no follow up notes to the written complaint.

A copy of the Administrators notebook was obtained and stated several actions to be implemented and that a meeting was held on a specific date with the SDM of the identified resident.

There was no Critical Incident System (CIS) report submitted to the Director related to the care concerns in the written letter that was submitted to the home by the SDM.

In an interview with the Administrator on a specific date they stated that they did not submit a CIS report to the Director or the written letter regarding the care concerns and the operation of the home that were received by the SDM for the identified resident and the home should have.

2) Another written letter was mailed and addressed by the SDM of an identified resident to the Administrator on a specific date. A summary of the written complaint stated that the SDM voiced concerns related to the operation of the home and care concerns of a resident.

Review of the complaint binder in the home showed that the home did not submit a CIS report related to the care of a resident or the operation of the home to the Director.

Review of the minutes in the complaint binder showed that the home met with the family to discuss the concerns on a specific date.

The Administrator stated they did not submit a CIS report to the Director or the written letter regarding the care concerns and the operation of the home by the SDM for the identified resident and they should have.

3) Another complaint report was sent to Member of Provincial Parliament (MPP). This complaint had also been sent to the DOC by email. The DOC confirmed the response back to the MPP that they received the complaint. A CIS report was first submitted to the Director of MOHLTC 41 days after the complaint was received by the home.

There were written concerns regarding the care of an identified resident from the SDM. The complaint binder showed that there was no follow up to the written complaint received at the home.

On a specific date the Administrator stated that they submitted the CIS late to the

Director and that they did not follow up to the written complaint as the resident was discharged from the home. The Administrator also stated that the expectation was that if a written complaint was received to the home regarding care or the operation of the home, they were to immediately submit the CIS report to the Director and include the written complaint. The Administrator further stated they were not doing a good job of this and recognized that they needed to start doing better.

The licensee has failed to ensure that a copy of the written complaint that was received relating to a matter that the licensee reports (or reported) to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a copy of the written complaint that is received relating to a matter that the licensee reports (or reported) to the Director under section 24 of the Act, and a corresponding written report documenting the response the licensee made to the complainant, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The license failed has to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A complaint was received by the Director of the MOHLTC related to a resident transfer and fall.

Review of PointClickCare (PCC) documentation and risk management showed that the resident had not been assessed after a fall on a specific date.

A Registered Practical Nurse (RPN) documented in a progress note in PCC that they were not aware that the resident had a fall on this date while they worked.

In an interview with the Director of Care (DOC) they said that they were not aware that the resident had a fall and agreed that there was no completed assessments related to the incident. The DOC also stated that when a resident had a fall a post fall assessment and a risk management report were to be completed and they were not.

The licensee has failed to ensure that when an identified resident had fallen that the resident was assessed and a post fall assessment was completed using a clinically appropriate assessment instrument that was specifically designed for falls.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) that stated that an identified resident had an incident that caused an injury.

The progress notes in PCC on a specific date stated that an incident that caused an injury to the resident occurred and they were transferred to hospital and received a specific intervention.

In an interview with the Director of Care (DOC) on a specific date they stated that the resident had a significant change in status and a Critical Incident System (CIS) report should have been submitted to the MOHLTC and was not.

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to an identified resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

The health care record (HCR) showed that an identified resident was discharged from the home on a specific date.

In an interview with a Manager of the home they stated that the resident had been assessed by Occupational Therapy (OT) related to their device as the resident was no longer safe in another device. They also said that the resident had fallen recently related to their device. A review of PCC and the identified resident's paper HCR showed that there was no completed assessment by the OT or consent records. The Manager said that the assessments that were completed by the OT could not be provided as they were not retained in the home.

On a specific date the Manager verified that they had spoken to the OT and that the OT had the assessment and consent. The Manager acknowledged that the assessments were a part of the clinical record in the home and were not to be removed and that this included consents, assessments, Assistive Devices Program (ADP) forms etc.

The OT faxed the ADP forms and the consent to the Manager on a specific date and stated that the assessment should be completed directly in Point Click Care (PCC) as a single point of repository of that information as part of the resident's clinical record.

On a specific date the Administrator stated that it was the expectation that any OT assessment completed was retained in the home as part of the clinical record for any resident seen by the OT.

The licensee has failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

Issued on this 7th day of February, 2018

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) :	SHERRI COOK (633), ADAM CANN (634), INA REYNOLDS (524), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2017_610633_0023
Log No. / No de registre :	025066-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 9, 2018
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF BRUCE 41 McGivern Street, P.O. Box 1600, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	BRUCELEA HAVEN LONG TERM CARE HOME - CORPORATION OF THE COUNTY OF BRUCE 41 McGIVERN STREET WEST, P.O. BOX 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Willie VanKlooster

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 CORPORATION OF THE COUNTY OF BRUCE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.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 protect three specific residents and all residents from abuse by anyone and shall ensure that another specific resident and all residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

A Complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged abuse of multiple residents. The complainant also stated that there were no Critical Incident System (CIS) reports submitted by the home to the Director as required.

The home's investigation records dated on specified dates included staff reports to the Director of Care (DOC) and the Administrator that an incident of alleged abuse occurred. The staff member continued to work in the home during the home's investigation and on a later specified date the staff member was provided education related to their approach.

In interviews with a specific PSW and Registered Practical Nurse (RPN) on specific dates they said they spoke with the identified resident and the staff agreed that the incident of abuse by the PSW towards the identified resident occurred. One RPN said that they had reported the PSW in the past.

In an interview with the identified resident, months after the alleged incident, they recalled the incident of abuse by the identified PSW.

In an interview with the identified PSW on a specific date they said that the incident was a misunderstanding.

In interviews with PSW's and RPN's on specific dates, they said that the incident was considered abuse.

When the DOC was asked, in an interview on a specific date, what they considered to be abuse they responded "according to the definitions in the abuse policy". The home's abuse policy defined the incident as abuse.

In an interview with Director of Care (DOC) on a specific date they stated that they felt like they failed the resident.

The licensee has failed to ensure that an identified resident was protected from abuse by an identified PSW on a specific date.

2. The home's investigation records related to another resident stated that the resident complained about this specific staff member being too abrupt and rough and the staff member would not listen to them. The resident also stated that they had problems with this staff member before. The investigation records included statements by the resident, their family member and staff that the incident occurred and the issue had been discussed in the past. The staff member was not off work pending the investigation completed by the DOC.

In an interview with a specific PSW on a specific date they said that they witnessed the identified staff member being very rough with the identified resident and they had told the staff member to stop and they did not listen. This PSW informed an RPN of their concern and was very upset and uncomfortable with what they saw.

In an interview with an RPN on a specific date they said that the resident told them that the identified PSW was too rough and they did not want them to do their care. The RPN also stated that the PSW had reported to them and this PSW was visibly concerned.

In an interview with the identified resident and their family member on a specific date, they said that the identified PSW was very rough with their care and they had told the staff that they were hurting them and they did not stop. The resident also stated that the PSW did not listen to them. The resident's family

member said that the resident does not usually complain and they had spoken about the incident for days after.

In an interview with the identified PSW on a specific date they agreed that the resident did not want them to do their care and denied being rough while providing care.

In an investigation note by the DOC and findings interview note with the DOC, Administrator and PSW on a specific date it was stated that there was a need for a gentler approach by the identified PSW.

In an interview with DOC and Administrator on a specific date, the DOC stated that they investigated the incident and thought that the PSW was not intentionally being rough. The DOC said that they had provided the PSW teaching related to their approach. The PSW was not off work pending the investigation completed by the DOC.

The licensee has failed to protect an identified resident from abuse by an identified PSW on a specific date.

3. The home's investigation records included that an identified PSW did not provide specific care on specific dates.

In an interview with the identified resident they said that they recalled a recent incident that resulted in the resident waiting one to two hours for care. The resident stated that they were uncomfortable and never did receive this care from the identified PSW. The resident also said that they had this PSW in the past and this PSW would say that they would come and assist them and they did not.

A Critical Incident System (CIS) was submitted to the MOHLTC by the DOC on a earlier specific date that stated that the identified resident did not receive this specific care and the resident was able to identify the identified PSW at that time. This report was amended by the DOC later and stated that "upon review of the investigation notes the resident was not able to identify the staff directly". The DOC's investigation "determined that another PSW had not provided the resident care".

The home's investigation records did not include all relevant documentation and

the PSW was not off work pending the investigation completed by the DOC.

In an interview with the identified PSW on a specific date they said that they recalled the incident however, they denied that the resident waited or was not provided care again by them on a specific date.

During interviews with a PSW and RPN's on specific dates they said that the incident was considered neglect.

The identified PSW received a written letter by the DOC on a specific later date that outlined a verbal warning that stated that the incident was considered abuse.

When the DOC was asked in an interview on a specific date what they considered to be neglect they responded "according to the definitions in the abuse policy. We also follow the MOH guidelines". The home's abuse policy stated that the incident was defined as neglect.

The licensee has failed to protect an identified resident from abuse by anyone and has failed to ensure that the identified resident was not neglected by staff on specific dates.

4. The home's investigation records stated that another identified resident had received a specific injury by a PSW and their family member was upset. Staff had reported the incident to the DOC on specific dates. The HCR for the resident documented that the injury was present and the resident recalled the incident and the identified PSW staff member. The records included an interview with the identified PSW and they agreed that the incident occurred. The PSW was not off work pending the investigation completed by the DOC.

The HCR for the identified resident on specific dates by the DOC stated "investigation initiated- resident not able to recall what happened or what staff did; notes indicate that no abuse took place; etiology of injury unknown as the resident was agitated".

In an interview with an RPN they stated that the resident had an injury on a specific location of their body. When the RPN was asked if they suspected that abuse may have occurred at the time they replied "yes".

In an interview with the identified PSW on a specific date they said that they recalled the incident and described the actions they took at the time of the incident. The PSW explained that they did not see the injury at the time, agreed that the resident sustained an injury and they understood that this was considered abuse.

In an interview with the identified resident on a specific date they were unable to recall the incident.

In interviews with PSW's and RPN's on specific dates they said that the incident was defined as abuse.

When the DOC was asked in an interview on a specific date what they considered to be abuse they responded "according to the definitions in the abuse policy". The home's abuse policy defined the incident as abuse.

In a "findings interview" completed by the DOC and notes taken by Administrator with the identified PSW on a specific date it was stated that the PSW needed to take a more gentle and less aggressive approach.

The PSW's employee file showed that a verbal warning and written warning had been given to the PSW related to resident approach and not following a resident's plan of care.

In an interview with the DOC on a specific date they said they investigated the incidents however, they did not believe they were intentional and were unable to substantiate at the time. The DOC stated that it was "more of an approach and they had provided the PSW with teaching".

The licensee has failed to ensure that an identified resident was protected from abuse by the identified PSW on on a specific date.

The licensee has failed to protect three residents from abuse by anyone and failed to ensure that another resident was not neglected by the licensee or staff.

The severity of the issue was determined to be actual harm/risk, the scope of the issue was a pattern and the home had a history of unrelated noncompliance. (633)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2018

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

Order / Ordre :

The license shall ensure:
-That a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported to the Director.
-That after normal business hours including weekends and statutory holidays, the immediate report of the incidents must be made using the Ministry's after hours emergency contact.

Grounds / Motifs :

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

In a specific time period eight incidents related to the alleged abuse towards eight identified residents occurred and there were no Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care (MOHLTC) immediately and the MOHLTC after hours pager was not called when appropriate.

A Complaint was received by the MOHLTC on a specific date to inform the Director of the alleged abuse of multiple residents and that there were no CIS reports submitted by the home to the Director as required.

The home investigation records for the eight identified residents included incidents of alleged abuse.

In interviews with PSW's, Registered Practical Nurses (RPN's) and Registered Nurses (RN's) on specific dates they all said that they did not report alleged abuse to the Director as this was the role of the Director of Care (DOC).

When the DOC was asked in an interview on a specific date what they considered to be abuse/neglect they responded “according to the definitions in the abuse policy”. They also follow the MOH guidelines”. The DOC also stated they completed most if not all of the alleged abuse investigations and they were the lead for the Abuse Program in the home. The DOC explained that their role was to complete all the CIS reports and all the follow-up that included staff discipline and education and also with the family. When asked what was the process and expectation for staff related to reporting abuse in the home, the DOC replied that all staff are aware of what to do. The DOC explained that staff were to immediately contact the charge nurse as they were the leads on the floor and the charge nurse would contact them or the Administrator to receive further direction. The DOC also said that they or the Administrator would report to the Director by use of the Critical Incident System (CIS) to the Ministry of Health and Long-Term Care (MOHLTC) and this would include the abuse incident and the investigation steps that were already taken. The DOC explained that the charge nurse would document the subjective comments of the resident and their objective observations at the time of the incident and this was usually by email but could also be written and directly if the DOC was present in the home. The DOC also stated that when an incident occurred after hours, staff were expected to call the DOC or Administrator for direction. The DOC also stated that rarely was the MOHLTC after hours pager used and they had access to complete mandatory reporting from home. The DOC said that staff were to

report alleged/actual abuse to them and they understood that the expectation was to report allegations of abuse/neglect to the Director immediately.

The home's abuse policy defined the eight incidents as abuse.

In an interview with the Administrator they said that the expectation for staff related to reporting alleged abuse was to email the DOC that would complete all the investigations and mandatory reporting to the Director. The Administrator also said that the DOC was the lead of the Abuse Program in the home. The Administrator stated that they do not submit CIS reports to the Director and if they were on call when the incident occurred they would contact the DOC.

In an interviews with the Administrator and DOC on specific dates they both said that they had some confusion about reporting to the MOHLTC. The DOC explained that they were investigating first to determine if abuse had occurred and needed to be sure of the allegation before reporting. The DOC explained that they felt that the incidents were not done intentionally. The DOC agreed that they should have completed CIS reports to the Director related to the the allegations of abuse towards the eight identified residents and they did not.

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

The severity of the issue was determined to be minimal risk, the scope of the issue was widespread and the home had a history of unrelated noncompliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall develop, implement and submit a plan to ensure the following:

1. That the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

2. The licensee must review the homes staffing pattern regarding Personal Support Workers hours on each home area and ensure there are enough Personal Support Workers/direct care staff to meet the residents assessed care and safety needs including bathing needs and preferences. Specifically, three identified residents and all residents are bathed at a minimum of twice weekly, on their scheduled bathing day, by the method of their choice and more frequently as determined by the resident's hygiene requirements.

3. That a procedure for tracking, monitoring and documenting all residents bathing, including missed bathing, is developed and implemented including who will be responsible.

Please submit the plan in writing to Sherri Cook, Long-Term Care Home Inspector-Nursing, Ministry of Health and Long-Term Care Inspections Division by fax at 519-873-1300 or by email at Sherri.Cook@ontario.ca by January 23, 2017.

Grounds / Motifs :

1. The Licensee has failed to provide for a staffing mix that is consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation.

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

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, by the family member of an identified resident. The complaint was related to regular bathing and hygiene.

An anonymous complaint was submitted to the MOHLTC on a specific date. In an interview in Stage 1 of the Resident Quality Inspection (RQI) on a specific date, another resident stated that "when there is a shortage of staff, I will miss my bath. I missed it about two weeks ago."

In another interview in Stage 1 of the RQI on a specific date, another identified resident stated they had to fight to get their bath. The resident explained that it caused stress to them when the bath staff did not come to work that day as they worried about getting their bath. The resident also said related to bathing that "it was bad for those residents that can't speak for themselves".

In an interview by another inspector on a specific date with another identified resident they said that they had concerns about missing their baths. The resident stated that they often missed their baths on a specific date and there were three occasions that they were not offered another bath. The resident stated that there were two Personal Support Worker's (PSW's) per floor, with one bath PSW that worked between the two wings on the floor. The resident also said that if the floor was short, it was the bath PSW that was pulled to work the floor rather than to administer the resident baths. In an interview with a Registered Practical Nurse (RPN) on a specific date they stated that this resident tracked their missed baths and they had missed five out of seven of their baths recently.

The plan of care for another identified resident was reviewed in Stage 2 of the RQI by another inspector related to other complaints that were received by the MOHLTC on specific dates. The complainant stated concerns with staffing shortages in the home. The resident did not receive their bath within a specific time period and the family had requested that the resident have a bath.

During interviews with the Ward Clerks on a specific date they said that the normal staffing levels in the home were three PSW day bath shifts, 13 PSW day shifts and 12 PSW evening shifts in total with one evening bath shift and six night PSW shifts. The Ward Clerks also said that on Monday and Friday there was an extra four hour bath shift and there was also a new full time float PSW that would help wherever needed. They further explained that there were two PSW's on each team (unit) and the one bathing staff was shared between each floor of 48 residents. The Ward Clerks also said that the secure unit had an extra PSW on days and for evenings there were two PSW's per team on every unit and one evening bath PSW that floats throughout the whole home. The Ward

Clerks also explained that when staff calls in they tried to call a staff to work for the same day or the next day in order to cover the missed baths. One Ward Clerk stated that the floors would call them to let them know who missed their baths and that there was no official documentation for tracking missed baths. Both Ward Clerks stated that the weekends were the worst for staffing and agreed that there have been residents lately that have missed their baths.

During an interview with the Director of Care (DOC) on a specific date they stated that there were 144 resident in the home with 24 residents on each resident home area (RHA). The DOC also said that the full Personal Support Worker (PSW) staffing levels in the home for days/evenings were two PSW's on each team/resident home area (RHA) with one bathing staff shared between each floor. The secure unit had an extra PSW on days and there was one evening bath PSW that floated throughout the whole home. The DOC also said that there was a new PSW float position that was implemented in September of this year and this PSW would go to where the needs of the residents were including baths. The DOC explained that a new process, "Bathing Algorithm" was also implemented in September of this year for tracking missed baths and was to be followed when working short staffed and in addition, the Ward Clerk would document the missed baths in the "bath binder". The DOC stated that the expectation for documentation related to missed baths included refusal and resident unavailable was to be completed by the PSW's in Point of Care (POC) and the PSW's were to also document "activity did not occur" in POC if a resident missed their bath on their scheduled day. The DOC also stated that missed baths would be also documented on the bathing lists contained in the "bathing binder" kept by the Ward Clerk. The DOC stated that they would expect to see a missed bath documented in both places.

The home's policy "Nursing-Staffing" it was noted that there was a provision for the organization of shifts and it included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work. The home's 2017 annual staffing evaluation was completed by the DOC and Ward Clerk and committee members on a specific date for a specific period. Under the sub-heading "Goals & Objectives for Period under Review" the following was documented:

1. "To have 100% continued bath coverage".
a. "When working short bath person is last to be pulled".
b. "Try to backfill the next day or the same day".

2. "To have 100% complement of staff".

Under the sub heading “Summary of Changes Made/Accomplishments” it was documented that “daily meeting in the fall and early winter to ensure baths are being done”.

The home’s action plan stated that items that required action included “ensuring residents were bathed twice a week by the method of their choice”. The action plan included “hiring four PSW’s, reviewing bathing daily, that all resident baths would be reviewed for resident preference, consistency with staffing with new schedules in January 2017 and assistance with help from the BSO staff, Ward Clerk, ADOC/RAI, program staff and environmental staff”. Long-term goals included “reviewing bath lists, baths shifts and the number of baths on each shift when working short”. The completed date was “on-going and January 2017”.

In an interview with a PSW by another inspector on specific date they said that there were 24 residents on their unit to care for. They also stated that there are two PSW's during the day shift and one bath staff floats from side to side between the units. The PSW also stated that they work short on weekends and lately they have been working short the majority of their shifts. The PSW further explained that the bath person often would get pulled and from the unit and would be put where the shortage of staffing was. The PSW also said that baths are being missed because of the shortage of PSW staff in the home.

In an interview with another PSW on a specific date they said that they do not do bath shifts. The PSW also said that they have been short PSW staff quite frequently, residents were not receiving their baths twice weekly and a missed bath was documented as “activity did not occur” in POC. When asked how the shortage of PSW staff impacted resident care, the PSW replied that “baths are missed, care takes longer, and residents are not washed as good as with a bath. When working short, staff would do a bed bath instead”. The PSW explained that the residents “don’t get the good clean”.

In an interview with another PSW on a specific date, they said that they have not done baths for a few years and the expectation was that a resident received a bath two times a week. The PSW stated that a missed bath was documented as “activity did not occur” in POC and they agreed that the home often ran short of staff. When asked how the shortage of PSW staff impacted resident care the

PSW replied that "care takes longer, some residents just get the basic care, the basics that's it, it's not fair to the residents, they deserve better".

In an interview with a Registered Practical Nurse (RPN) on a specific date they said that the residents that have baths scheduled on the weekends would often miss their baths and that this was "a real issue". They also said that missed baths were not documented and that "many residents have missed their baths for days". The RPN explained that the residents were given a bed bath instead and stated that working short had become the "norm" as "every weekend we are short". The RPN also said that this has been going on since May of 2015. When asked how the shortage of PSW staff impacted resident care the RPN replied that it "impacts in every way. Everybody does their hardest, residents wait longer, eight out of my last ten shifts we were short staffed and it is not possible to get everything done". The RPN also stated that residents that were able to complain would get their baths before residents that can't speak for themselves.

In an interview with another RPN on a specific date they said that a staff had called in and the bath staff was called to work the floor. The RPN explained that residents would not receive their baths today unless someone stayed or came in. The RPN also said that the residents would not be given a bath or a shower today and a bed bath would be given instead. The RPN explained that a missed bath was "not recorded anywhere. It shows up as not done". The RPN also stated that "we are so short staff. I don't think we should be filling the empty beds. We do not have the staff to properly look after the residents". The RPN explained that there are 24 residents per unit with two PSW's, one nurse and a bath person for the floor if all the staff were here. The RPN further explained that one PSW had 12 residents and they had to provide care with several lifts on the unit that required two person assistance to transfer the residents. The RPN agreed that all residents did not get their baths twice a week.

In an interview with another PSW on a specific date they said that they were the bath float person, and the bath staff from the morning was pulled to the floor today. The PSW also said that the expectation was that residents were bathed twice a week and that it was "a staffing crisis right now, plain and simple". The PSW explained that when a resident didn't get a bath it was not charted and they had never charted under "activity did not occur" in POC. The PSW further explained that the residents today would get "am and pm care" and no bed bath would be given. The PSW stated that staffing had been short in the last year and there were many unfilled PSW lines and the PSW agreed that weekends were

particularly short staffed. When asked how the shortage of PSW staff impacted resident care the PSW replied that there was not enough staff on the day shift to do the care that the residents needed even when they were not short staffed. The PSW agreed that all residents did not get their baths twice a week.

The plan of care for a three resident sample was selected for review related to bathing. The health care record (HCR) stated that these residents had missed their baths 12 percent of the time in a specific time period and "activity did not occur" was not documented consistently.

The Ward Clerks reviewed the HCR for the three identified residents and agreed that the residents missed their baths and there was no documentation completed by the PSW's that the bathing "activity did not occur".

The "bathing algorithm" as the process for tracking missed baths in the home, that was not dated, stated that the DOC "would be provided a list of resident names of who did not receive a bath/shower on their scheduled day".

A Ward Clerk reviewed the "bathing binder" and agreed that there was no documentation related to which residents missed baths and when this occurred within a specific period of time. The Ward Clerk also reviewed the paper PSW schedules and their computer documentation and stated the following related to PSW staffing on the specific dates that the three identified residents missed their baths:
-Short a full PSW staff for days, and short a night PSW from 0200 to 0600 hours, short one PSW staff on the 4th floor for a full shift.
-B4 short on the 4th floor- One full time PSW shift and did not have the bath shift PSW.
-No residents received their baths that day. No PSW bath shifts.
-Short four hours PSW bath, other staff stayed to complete other baths.
-Short 24 hours of bath shifts, called in the next day for 16 hours to make up the baths.
-Short 16 hours PSW staff.

The "PCC Facility Bulletin Board - Bruce County Homes - Brucelea Haven" on specific dates stated the following:
-Pull BSO to fill on 3 west, as we are short staff.
-Short staff on 3rd floor west side, bath PSW pulled to work the floor for today.
-Floor 4 is short on days today. RPN working both sides".

The staffing schedules for a specific period of time that were provided and calculated by a Ward Clerk on a specific date documented that on 22/46 days the home was without full complement of PSW's staff (48 percent) with one or more PSW shifts not filled on those days.

In an interview with the Administrator on a specific date they said that baths have been an issue lately and they had thought they were doing better but in the last three months they had slid back. The Administrator explained that they currently had 15 PSW lines not filled with some coverage from casual staff and that they were recruiting PSW staff constantly.

In an interviews with the Director of Care (DOC) on specific dates they said that the expectation was that all residents received a bath twice weekly by method of their preference and they agreed that the three identified residents had not. The DOC also agreed that when a resident bath was missed they would be offered a bed bath instead. The DOC also stated that the expectation was that the "bathing algorithm" and "bathing binder" for tracking missed baths in the home was followed by staff and they agreed that it had not been. The DOC also stated that the reason for the missed baths was that they were both short PSW staff and there were PSW staff that did not do bath shifts. The DOC stated that despite the action plan implemented in the home and the strategies for missed baths, residents were still not getting their baths as required. The DOC agreed that there was a process and documentation issue related to tracking resident's missed bathing and that this was in despite of what they had been working on over the past year. The DOC said that that monitoring and audits were not being completed related to tracking resident care and this included bathing.

The licensee has failed to provide for a staffing mix that is consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation including that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

The severity of the issue was determined to be minimal harm or potential for actual harm, the scope of the issue was a pattern and the home had a history of related noncompliance. (633)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, appropriate action is taken in response to every such incident; and any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. Specifically, the licensee shall ensure that:
-The Administrator, the Director of Care, and all other management staff of the home will complete a comprehensive review of the process for investigating abuse and neglect, roles and responsibilities, as well as immediate and long term appropriate actions to be taken including but not limited to O.Reg. 79/10, s 97 (1) (2) related to substitute decision-maker notifications and O.Reg. 79/10, s 98 related to Police notification.This process shall include documenting and maintaining investigation records.This process shall be implemented in the home and documented.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by licensee or staff or anything else provided for in the regulations, that the licensee knows of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident.

There were no CIS reports immediately submitted to the Director for eight incidents of alleged abuse to residents over a specific period of time. In addition, all investigations were not completed immediately and corrective action was not taken in response to each incident.

The home's investigation records showed alleged incidents of abuse that were reported to the DOC by residents and staff and the home did not take appropriate action in response to each incident. The staff member was not placed off work pending the investigations completed by the DOC and all signed statements from staff were not included. The staff member received a verbal and a written warning at a later date.

The home's abuse policy in effect at the time of the incidents, "Prevention of Abuse and Neglect" stated that:
-"To ensure that every incident and suspicion of abuse is investigated, documented and reported".
-"The supervisor is expected to immediately send an employee away from the workplace pending a thorough investigation and decision regarding disciplinary action".
-"Documentation will be recorded as soon as possible after the abuse is reported ".
- A written incident report would be completed that included written signed statements from all witnesses, resident status, assessment for injury and future prevention".
-"The Administration would notify the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident".
-"The resident and the resident's SDM, of any, are notified of the results of the

investigation required under subsection 23(1) of the Act, immediately upon completion of the investigation".
-"Police shall be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence".
-"All cases of validated abuse will remain on the staff employment file".
-"All validated abuse will be issued disciplinary action in the form of progressive suspensions which are individually reviewed and issued".
-"Mandatory abuse prevention training is required to be completed during the time of the suspension and submitted prior to returning to work".

The employee file for the identified staff member did not include a record of all cases of validated abuse, progressive suspensions, which were individually reviewed and a record of mandatory abuse prevention training completed by the staff member while suspended and before returning to work. The employee file only included the two letters of suspension/disciplinary action on two later dates.

In an interview with the identified staff member on a specific date they said that were aware of the alleged incidents of abuse. The staff member clarified that they received two warnings, a verbal and written warning on the same day however, they had not received any abuse education related to any alleged incidents. The staff member also said that the only time they were off work was then. The staff member agreed that they caused an injury to two residents and they denied all other alleged incidents.

O. Reg. 79/10, s. 97 (1) states that "every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident".
O. Reg. 79/10, s. 97 (2) states that "the licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation".
O. Reg. 79/10, s. 98 states that "every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged,

suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence".

In an interview with the DOC and Administrator on specific dates they said that they were not withholding information or critical incidents and they had some confusion related to reporting to the Director. The DOC said that they had investigated the alleged incidents and needed to be sure of the allegation before reporting to the Director. The DOC agreed that they did not submit any CIS reports or results of their investigations to the Director. The DOC also agreed that their investigations did not include all written statements from all witnesses at the time of the incidents and some interviews were missing dates. The DOC also agreed that they did not speak with the resident's Substitute Decision Maker (SDM)/Power of Attorney (POA) related to either the allegations of abuse or the results of their investigations and they also did not contact the police. The DOC explained that they had felt like the issue was more related to the approach while providing care and they had provided them with teaching related to their approach. The DOC said that they usually placed an employee off work with pay during their investigation and the staff member was only off pending the results of their investigation on a later date and they had received a verbal and written warning at that time.

In an interview with the Administrator on a specific date they said that there were only two times that the staff member was off and that was at a later date pending the results of their investigation and again on when the inspectors were present in the home. The Administrator also confirmed that the staff member resigned on a specific date.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by licensee or staff or anything else provided for in the regulations, that the licensee knows of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident.

The severity of the issue was determined to be minimal risk, the scope of the issue was widespread and the home had a history of unrelated noncompliance.

(633)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2018

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 : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Order / Ordre :

The licensee must report to the Director the results of every investigation of alleged, suspected or witnessed incident of abuse of a resident by anyone; neglect of a resident by the licensee or staff or; anything else provided for in the regulations; and every action taken in response to every such incident.

In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include all material that is provided for in the regulations specifically but not limited to O.Reg. 79/10, s.104 (1)(2)(3) that states that the licensee shall include the following material in writing:
(1) A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
(2) A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
(3) Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
(4) Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
(5) The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

Grounds / Motifs :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The home did not report to the Director the results of every investigation and

every action taken related to eight incidents of alleged abuse/neglect that occurred during a specific time period.

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

The home's investigation records related to the alleged abuse/neglect of the eight identified residents included interviews by the Director of Care (DOC) with the residents, some family members and some interviews and meetings with staff. The investigation records also document meetings with the staff member and DOC and the Administrator. The home's investigation records did not include written incident reports and signed statements of all witnesses and in

some cases the dates of the interviews were missing. The investigation records also did not include whether a physician or registered nurse in the extended class was contacted, what other authorities were contacted, whether a family member, person of importance or a substitute decision-maker of any resident involved in the incidents was contacted and the name of such person or persons, appropriate actions taken in response to each incident, the outcome or current status of the individual or individuals who were involved in the incident and the long-term actions planned to correct the situation and prevent recurrence.

In an investigation note dated titled “Complaints/Investigations” stated that the DOC reviewed the staff member's approach on specific dates.

The staff member also received a written letters by the DOC on specific dates that outlined a verbal and written warning. The PSW was off working pending the DOC’s investigation at a later date and was required to review the home’s whistleblower policy.

In interviews with the Administrator and DOC on specific dates they both said that they had some confusion about reporting to the MOHLTC. The DOC explained that they were investigating first to determine if abuse had occurred and needed to be sure of the allegation before reporting to the Director. The DOC explained that when they had investigated the staff member related to all allegations of abuse/neglect that were received by residents and staff they had thought that the staff member's actions were not intentional and they had provided them teaching related to their approach. The DOC agreed that they should have completed CIS reports and submitted the results of their investigations to the Director related to the allegations of abuse towards the eight identified residents and they did not.

The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The severity of the issue was determined to be minimal risk, the scope of the issue was widespread and the home had a history of unrelated noncompliance. (633)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
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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

Name of Inspector / Nom de l'inspecteur : Sherri Cook

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