Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 14, 2017	2017_665551_0016	014827-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

CARLINGVIEW MANOR
2330 CARLING AVENUE OTTAWA ON K2B 7H1

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

MEGAN MACPHAIL (551), ANANDRAJ NATARAJAN (573), RENA BOWEN (549), SUSAN LUI (178)

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): August 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28 and 29, 2017.

The following logs were completed as part of this inspection:
- related to allegations of staff to resident abuse: 016067-17, 011852-17, 012244-17, 012746-17, 009691-17, 004542-17, 012620-17 and 018277-17
- related to allegations of resident to resident abuse: 012241-17, 007898-17, 010476 -17 and 014596-17
- related to incidents that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition: 003085-17, 003950-17, 016923-17, 015938-17, 009210-17, 016922-17, 019521-17, 004303-17 and 016012-17
- related to medication administration: 027306-16 and 001548-17

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Personal Support Workers (PSWs), Registered Nursing Staff, Dietary Aides, Housekeeping Staff, Maintenance Staff, a Recreation Programmer, an Occupational Therapist, a Physiotherapist, the Registered Dietitian, the Staffing Co-ordinator, Clinical Managers, the Resident Care Co-ordinator, the Director of Care, the Assistant Executive Director and the Executive Director.

During the course of the inspection, the inspector(s) toured residential and non-residential areas, reviewed health care records, reviewed selected policies and procedures, observed a meal service and a medication pass and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **11 WN(s)**
- **9 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy that promotes zero tolerance

of abuse and neglect of residents is complied with.

The licensee's policy ADMIN-O10.0, revised July 31, 2016, titled Mandatory Reporting of Resident Abuse or Neglect indicates under the heading: Procedure- Internal: Anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift.

The licensee submitted a critical incident report (CIR) to the Director on a specified date indicating an alleged abuse of resident #052 which had occurred several weeks earlier.

Inspector #549 reviewed the licensee's investigation documentation which indicated that PSW #102 reported to the Staff Coordinator on a specified date that resident #052 had approached her during her shift several weeks earlier and had indicated to PSW #102 that "she hit me, call the police".

During an interview on August 15, 2017, PSW #102 indicated to Inspector #549 that she was listening to the Staff Coordinator talking to staff about the Resident's Bill of Rights and thought after the discussion that she should report what resident #052 had told her several weeks prior. During the interview PSW #102 also indicated to the inspector that she is aware that resident #052 was telling her that he/she was hit and that this action constitutes abuse and that she should have reported it immediately to her supervisor.

The licensee failed to ensure compliance with their Mandatory Reporting of Resident Abuse or Neglect policy# ADMIN-O10.0 when PSW#102 did not immediately report the alleged abuse of resident #052.

[log 004542-17] [s. 20. (1)]

2. The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's policy ADMIN1-P10-ENT, last revised July 31, 2016, titled Resident Non-Abuse Program indicates under the heading: Standard bullet one: Revera has a zero tolerance of abuse and neglect. The licensee's definition of Psychological/Mental/Emotional abuse is as follows: Any mistreatment or a Resident/client that may hurt that person's sense of identity, dignity or self-worth or is likely to cause fear for their safety or wellbeing.

A critical incident report (CIR) was submitted to the Director by the licensee on a specified date indicating that the Registered Dietitian (RD) observed PSW #128 being rough when providing care to resident #053.

Inspector #549 reviewed the licensee's investigation documentation which indicated that RD #131 had some nutritional concerns related to resident #053. Resident #053 was in bed sleeping when RD #131 went to observe the resident's intake at the lunch meal. PSW #128 indicated to RD #131 that the resident did not sleep well and that she was going to let the resident sleep a little longer. The resident did not get up for breakfast. When RD #131 went back to the resident's room at 1240 hours, the resident was still in bed sleeping. RD #131 voiced to PSW #128 how important it is that the resident be offered food and fluids. RD #131 indicated in the licensee's investigation documentation that PSW#128 then took off the resident's blankets and roughly began to put on the resident's pants and slippers before waking the resident. PSW #128 then swung the resident's legs off the side of the bed and pulled the resident to an upright position by the resident's arm to get the resident to stand. RD #131 indicated that the resident became wide eyed and began breathing very rapidly as though nervous. RD #131 then remained with the resident and consoled and reassuranced the resident that he/she was okay.

During an interview on August 15, 2017, PSW #128 indicated to Inspector #549 that she was rubbing the resident's legs to get the resident to wake up however, RD #131 did not see that. PSW #128 indicated during the interview with the inspector that she may have been in a rush to get the resident up. She also indicated to the inspector that she would do things differently now but at the time did not think she was being abusive towards resident #053.

During an interview with RD #131 on August 21, 2017 it was indicated to Inspector #549 that she felt PSW #128 was abrupt and rough with resident #053. RD #131 also indicated to the inspector that the PSW did not rub the resident's legs or gently awaken the resident from a deep sleep before she started to get the resident out of bed.

The licensee failed to ensure compliance with their Resident Non-Abuse Program policy # ADMIN1-P10-ENT when PSW #128 roughly and abruptly got resident #053 out of bed.

[log 009691-17] [s. 20. (1)]

3. The licensee has failed to ensure that their written policy that promotes zero tolerance

of abuse and neglect of residents is complied with.

The licensee's policy ADMIN1-P10-ENT, last revised July 31, 2016, titled Resident Non-Abuse Program indicates under the heading: Standard bullet one: Revera has a zero tolerance of abuse and neglect. The licensee's definition of Verbal abuse is as follows: inappropriate verbal or non-verbal communication directed towards the Resident/Client. Examples provided by the licensee: the inappropriate tone of voice, abusive language, yelling, swearing, rude, offensive or sexual comments or gestures.

A critical incident report (CIR) was submitted to the Director by the licensee on a specified date indicating an alleged abuse of resident #054 that took place several months prior however, the licensee is unsure of the exact date. The critical incident indicates that a family member of another resident was visiting, and from across the hallway overheard a male registered practical nurse (RPN) saying "stay in your room", "stay there", "be quiet" in a very aggressive voice. The visitor said that a hard "slap" was then heard but couldn't say where this came from other than the room, nor where or whom it was directed at.

It was later identified by the licensee that the male RPN was RPN #129, and the resident involved was resident #054.

Inspector #549 reviewed the licensee's investigation documentation which indicated that a visitor observed a resident yelling in the hallway and witnessed RPN #129 bring the resident into the resident's room and then heard the RPN speaking aggressively to the resident and a loud smack sound. The visitor indicated having thought that it was RPN #129 hitting his own leg in a way to enforce the resident to calm down.

During an interview on August 19, 2017 with the Executive Director and Assistant Executive Director it was indicated to Inspector #549 that RPN #129 is no longer employed by the licensee.

The licensee failed to ensure compliance with their Resident Non-Abuse Program policy # ADMIN1-P10-ENT when RPN #129 was overheard yelling and being verbally aggressive with resident #054.

[log 012620-17] [s. 20. (1)]

Additional Required Actions:

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

WN #2: 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. (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 the results of the abuse investigation were reported to the Director.

A CIR was submitted to the Director, under LTCHA, s. 24 on a specified date outlining an allegation of staff to resident abuse.

In an interview with RN #152 on August 25, 2017, she indicated that on a specified date, an allegation of staff to resident abuse involving resident #030 and PSW #142 was reported to her. The allegation of abuse was reported by the RN to the on-call manager (the Resident Care Co-ordinator).

In an interview with the DOC on August 24, 2017, she indicated that the licensee's investigation had found that the allegation of abuse against PSW #142 was inconclusive. The CIR was not amended to report this result to the Director.

[log 012244-17] [s. 23. (2)]

2. The licensee has failed to ensure that the results of every investigation that resulted

from abuse or neglect is reported to the Director.

The licensee submitted a critical incident report (CIR) to the Director on a specified date indicating an alleged abuse of resident #052.

The licensee's investigation documentation reviewed by Inspector #549 indicated that the investigation related to the alleged abuse of resident #052 had concluded that the licensee could not verify that the alleged abuse took place.

During an interview with the Executive Director and the Assistant Director it was indicated to Inspector #549 that the results of the investigation of the alleged abuse of resident #052 were not reported to the Director.

[log 004542-17] [s. 23. (2)]

3. The licensee has failed to ensure that the results of every investigation that resulted from abuse or neglect is reported to the Director.

The licensee submitted a critical incident report (CIR) on a specified date to the Director indicating an alleged abuse of resident #053.

Inspector #549 reviewed the licensee's investigation documentation which indicated that the investigation had concluded that the alleged abuse was founded. Inspector #549 was unable to locate any documentation to indicate that the Director was informed of the results of the alleged abuse investigation involving resident #053.

During an interview on August 17, 2017 the Director of Care (DOC) indicated to Inspector #549 that the Director was not informed of the investigation results of the alleged abuse of resident #053.

[log 009691-17] [s. 23. (2)]

4. The licensee has failed to ensure that the results of every investigation that resulted from abuse or neglect is reported to the Director.

The licensee submitted a critical incident report (CIR) to the Director on a specified date indicating an alleged abuse of resident #054.

Inspector #549 reviewed the licensee's investigation documentation which indicated that the investigation had concluded that the alleged abuse was founded. Inspector #549 was unable to locate any documentation to indicate that the Director was informed of the results of the alleged abuse investigation involving resident #054.

During an interview on August 17, 2017 the Assistant Executive Director indicated to Inspector #549 that the results of the investigation of the alleged abuse of resident #054 was not reported to the Director.

[log 012620-17] [s. 23. (2)]

5. The licensee has failed to ensure that the results of every investigation that resulted from abuse or neglect is reported to the Director.

A critical incident report (CIR) was submitted to the Director by the licensee on a specified date indicating the alleged abuse of resident #063.

During an interview with Clinical Manager #114 on August 21, 2017, it was indicated to Inspector #549 that the licensee's investigation related to the alleged abuse of resident #063 had concluded that the alleged abuse was inconclusive.

The DOC indicated on August 21, 2017 during an interview with Inspector #549 that the results of the investigation related to resident #063 were not reported to the Director.

[log 018277-17] [s. 23. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the results of the abuse investigation are reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it is based to the Director.

A Critical incident report (CIR) was submitted to the Director by the licensee on a specified date related to an alleged sexual abuse of resident #065 involving resident #064.

The critical incident report indicates that the alleged sexual abuse occurred on a specified date and was reported to RPN #148 who then reported to the charge nurse, RN #152 on the same day.

Clinical Manager #114 was the on call manager on the specified date. He indicated during an interview on August 24, 2017 with Inspector #549 that the charge nurse did not notify him of the alleged sexual abuse of resident #065 on the specified date.

Clinical Manager #126 indicated during an interview on August 24, 2017 with Inspector #549 that she was called into work on the specified date to work the night shift in the home. Clinical Manager #126 indicated during the same interview that she was aware of the alleged sexual abuse of resident #065 as it was reported during the shift change

report. Clinical Manager #126 indicated that she did not notify the Director of the alleged sexual abuse as she indicated that she had thought RN #152 had already reported it. The alleged sexual abuse of resident #065 was reported to the Director the following day.

Inspector #549 was able to contact RPN #148 on August 28, 2017. RPN #148 indicated during a telephone interview that she had reported the incident of alleged sexual abuse to RN #152 immediately after becoming aware of the incident.

During an interview with RN #152 on August 28, 2017, it was indicated to Inspector #549 that she recalls the incident and the usual process is to call the on call manager and report the alleged sexual abuse. RN #152 cannot recall who the on call manager was that she reported the alleged sexual abuse incident to on the specified date.

The licensee failed to report the alleged sexual abuse of resident #065 immediately to the Director.

[log 012241-17] [s. 24.]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money was immediately reported to the Director.

A CIR was submitted to the Director, under LTCHA 2007, s. 24, on a specified date outlining a suspicion of financial abuse involving resident #062.

According to the CIR, on a specified date, resident #062 reported to a registered staff member that he/she was missing money. The home began an immediate investigation.

The Director was not immediately notified of the suspicion of misuse or misappropriation of resident #062's money; the Director was not notified until two days later. In an interview with the DOC, she indicated that the Director should have been notified of the suspicion of financial abuse immediately.

[log 011852-17] [s. 24. (1)]

3. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone was immediately reported to the Director.

A CIR was submitted to the Director, under LTCHA, s.24, on a specified date outlining an allegation of staff to resident abuse.

In an interview with RN #152 on August 25, 2017, she indicated that on a specified date an allegation of staff to resident abuse involving resident #030 and PSW #142 was reported to her. The allegation of abuse was reported by the RN to the on-call manager (the Resident Care Co-ordinator).

The Director was notified of the allegation the following day which is not immediately. In an interview with the DOC, she indicated that the Director should have been notified of the alleged abuse immediately.

[log 012244-17] [s. 24. (1)]

4. The licensee failed to ensure that that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it is based to the Director.

A critical incident report (CIR) was submitted to the Director by the licensee on a specified date indicating an alleged abuse of resident #054 that took place several months prior, however the licensee is unsure of the exact date. The critical incident indicates that a family member of another resident was visiting, and from across the hallway overheard a male registered practical nurse (RPN) saying “stay in your room", "stay there", "be quiet" in a very aggressive voice. The visitor said that a hard "slap" was then heard but couldn't say where this came from other than the room, nor where or whom it was directed at. It was later identified that the male RPN was RPN #129, and the resident involved was resident #054.

Inspector #549 reviewed the licensee’s investigation documentation which indicated that Clinical Manager #114 and the Resident Care Coordinator became aware of the allegation of abuse on the morning of a specified date.

During an interview with the Executive Director on August 17, 2017, it was indicated to Inspector #549 that she does not recall why the alleged incident of abuse was not reported immediately to the Director.

[log 012620-17] [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that suspected abuse by anyone is immediately reported to the Director, to be implemented voluntarily.

WN #4: 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 with resident #069's transfers.

A Critical Incident Report (CIR) was submitted to the Director regarding an incident for which resident #069 was sent to the hospital and diagnosed with an injury. The CIR indicated that the origin of the resident's injury was unknown.

On a specified date, resident #069 was admitted to the home with multiple diagnosis. A review of resident #069's MDS assessment indicated that the resident needs assistance with activities of daily living (ADLs). Further the assessment identified that the resident required extensive assistance requiring two person physical assistance with the use of a sit to stand lift for transfers.

Inspector #573 reviewed resident #069's transfer assessment which indicated "Mechanical Sit/Stand lift and two staff member required". A physiotherapy assessment for transfers status indicated that resident #069 was two person assist with a mechanical sit to stand lift. A review of the written plan of care for transfers indicated that the resident required a sit to stand lift with two staff members for transfers.

On August 25, 2017, Inspector #573 reviewed resident #069's health care record.

Progress note documentation on a specified date indicated that the RPN observed swelling on the resident's body part and noticed that the body part was warm and tender. The on call physician was notified. Nursing progress note documentation, one day later, indicated that bruising was observed on the resident's specific body part. The resident was assessed by home's Nurse Practitioner. Two days after the initial swelling was observed, a diagnosis was made, and the resident was transferred to hospital.

On August 25, 2017, Inspector #573 spoke with PSW #108, who indicated that on a specified date, PSW #159 who had provided a shower to resident #069 was calling for help from the shower room. PSW #108 indicated having observed that resident #069 was sliding from the shower chair, and that PSW #159 was holding the resident's hand.

On August 28, 2017, during an interview with PSW #160, it was indicated that on a specified date, the PSW went to the shower room to help PSW #159 since resident #069 was sliding out from the shower chair. PSW #160 indicated that in the shower room, it was observed that resident #069 was leaning and twisted towards one side of the shower chair, and that the resident's left bottom was still in contact with the shower chair. PSW #160 indicated that it was observed that the shower chair safety belt was not applied to the resident. Further PSW #160 indicated that assistance was provided to PSW #159 to reposition the resident in the shower chair and to transfer the resident from the shower chair to resident's wheel chair without using a sit to stand lift.

On August 29, 2017, Inspector spoke with RN #161, who indicated that on on a specified date, PSW #159 reported that resident #069 was crying a lot during the shower. The RN indicated that the resident usually cries on shower days due to behaviours. RN #161 indicated that the resident was observed in the shower room, and when the RN inquired if resident #069 was okay, the resident nodded his/her head indicating that he/she was okay. Further the RN indicated that PSW staff members did not inform or report to the RN about resident #069's incident of sliding out from the shower chair.

On August 29, 2017, Inspector #573 spoke with the home's physiotherapist (PT). The PT indicated to the inspector that resident #069 required a sit to stand lift with two staff members for all transfers.

Inspector #573 spoke with the DOC, who indicated that the home conducted an internal investigation related to the cause of resident #069's injury. The DOC indicated that they found out that on four ocassions, four PSW staff members did not follow the safe transfers protocol while transferring resident #069. The DOC indicated that on two

specified dates, the resident's shower days, PSW #159 transferred resident #069 alone without using a sit to stand lift. Further the DOC indicated to Inspector #573 that PSW staff members failed to follow the home's safe transfers protocol and procedure while transferring resident #069.

[log #016012-17] [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee consult regularly with the Residents' Council, and in any case, at least every three months.

On August 17, 2017, Inspector #573 spoke with the President of the Residents' Council, who indicated to the Inspector that the licensee does not consult regularly with the Residents' Council.

On August 17, 2017, during an interview with the Home's Program Manager, she indicated to the Inspector that she was assigned to assist the Residents' Council. Further the program manager indicated that she was not sure when the licensee representative consulted with the Residents' Council.

On August 17, 2017, the Executive Director indicated to Inspector #573 that she was designated to represent the licensee. Further she indicated that it been a year since she had consulted with the Residents' Council. [s. 67.]

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 licensee consults regularly with the Residents' Council, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that that all PSW staff received annual re-training in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

The LTCHA, 2007, c. 8, s. 76 (2) 11, and O. Reg. 79/10, s. 218, 2, requires that all staff of the home will be provided training in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. LTCHA, 2007, c. 8, s. 76 (4) and O. Reg. 79/10, s. 219 (1) requires that all staff who were required to receive this training will receive re-training annually.

On August 29, 2017, Inspector #178 interviewed the home's Staff Coordinator. The Staff Coordinator indicated that she coordinates and provides staff education, and has been in this role since September 2016. The Staff Coordinator indicated to Inspector #178 that the most recent re-training in safe ambulation, (mechanical) lifts and transfers (SALT) for PSW #151 and PSW #158 took place on June 3, 2015. The Staff Coordinator indicated that all registered nursing and PSW staff should receive SALT re-training annually, however the home's education records indicate that PSW #151 and PSW #158 did not participate in SALT re-training in 2016. The Staff Coordinator indicated that she was told by one of the individuals who provided SALT re-training in 2016, that PSW #151 and

PSW #158 were unable to attend the re-training on the day it was offered, and as a result were not re-trained in 2016.

Review of the home's education records by Inspector #178 indicated that PSW #151 and PSW #158 last attended SALT training on June 3, 2015.

[log 004303-17]

On August 29, 2017, related to a CIR involving resident #069, Inspector #573 requested from the Staff Coordinator the 2014, 2015, 2016, and 2017 training records regarding staff re-training in safe ambulation, (mechanical) lifts and transfers (SALT) for specific PSW staff members. Review of the training records indicated that the most recent re-training in SALT took place in October 2015 for PSW #159, May 2015 for PSWs #164 and #165, and November 2014 for PSW #162.

During an interview with Inspector #573 on August 29, 2017, the Staff Coordinator indicated that the most recent re-training in safe ambulation, lifts and transfers (SALT) was in 2015 for PSW #159, PSW #164 and PSW #165, and in 2014 for PSW #162.

[log 016012-17] [s. 76. (7) 6.]

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 all staff receive annual retraining in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids that is relevant to the staff member's responsibilities, to be implemented voluntarily.

WN #7: 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. (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 (SDM) was notified of the results of the alleged abuse of a resident.

A critical incident report (CIR) was submitted to the Director by the licensee on a specified date indicating that the RD observed PSW #128 being rough when providing care to resident #053.

The licensee notified resident #053's SDM of the alleged abuse. Inspector #549 reviewed the licensee's alleged abuse investigation documentation which indicated that the alleged abuse investigation was completed on a specified date however, the inspector was unable to locate any documentation indicating that resident #053's SDM was notified of the results of the alleged abuse investigation.

During an interview on August 17, 2017 the Director of Care (DOC) indicated to Inspector #549 that resident #053's SDM was not notified of the results of the alleged abuse investigation.

[log 009691-17] [s. 97. (2)]

2. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified of the results of the alleged abuse of a resident.

A critical incident report (CIR) was submitted to the Director by the licensee on a specified date indicating that PSW #102 reported to the licensee that resident #052 had approached her during her shift and said, "She hit me, call the police" several weeks earlier.

Inspector #549 reviewed resident #052's health care file which indicated that the resident was admitted to the home in 2015 and had several medical diagnosis.

Upon review of the resident's progress notes it was indicated that the resident's SDM was notified of the alleged abuse, however no documentation was located to indicate that the SDM was notified of the results of the alleged abuse investigation.

On August 16, 2017 during an interview with the Executive Director and the Assistant Executive Director it was indicated to Inspector #549 that the SDM for resident #052 was not informed of the results of the alleged abuse investigation.

[log 004542-17] [s. 97. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's SDM is notified of the results of the alleged abuse investigation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

Review of the submitted Critical Incident Report (CIR) indicated that on a specified date, RPN #125 accidentally administered seven medications to resident #051 which were meant for another resident. None of these medications had been ordered for resident #051. The physician was notified, and the resident was transferred to hospital for assessment.

In an interview with Inspector #178 on August 16, 2017, RN #124 indicated that on a specified date, resident #051 was administered medications that had not been prescribed for the resident, and as a result the resident was sent to hospital for assessment. The resident returned to the home later that night in stable condition but was drowsy. The resident did not suffer long term harm as a result of the medication error.

027306-16 [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to resident #050 in accordance with the directions for use specified by the prescriber.

Review of resident #050's current plan of care indicated that the resident has specific medical diagnosis and exhibits responsive behaviours.

Review of resident #050's physician's orders indicated that on a specified date, the physician ordered that the resident's evening dose of a specific medication be increased. Review of the resident's present MAR indicates that the evening dosage of the specific medication was not increased as per the physician's order on the specified date.

During an interview with Inspector #178 on August 22, 2017, the DOC indicated that the physician's order on a specified date to increase resident #050's specific medication had been missed, and was currently being investigated by the home as a medication error. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident, and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During this inspection, inspectors made the following observations in residents' shared washrooms and tub/shower rooms which present a pattern of non-compliance with potential risk to residents related to infection prevention and control.

On August 08, 09 and 10, 2017, the following unlabelled personal care items were observed by inspectors in the residents' shared washrooms:

In a specified room: Inspector #551 observed two used unlabelled tooth brushes and one used unlabelled denture brush on the counter of this shared washroom.

In a specified room: Inspector #551 observed one used unlabelled tooth brush, one used unlabelled comb and one used unlabelled disposable razor on the counter of this shared washroom.

In a specified room: Inspector #551 observed one used unlabelled hairbrush and one

used unlabelled deodorant stick in an unlabelled shower caddy in this shared washroom.

In a specified room: Inspector #573 observed six used disposable razors and one nail clipper in an unlabelled blue bin in this shared washroom.

In a specified room: Inspector #573 observed two used tubes of tooth paste, two used tooth brushes, two used bars of soap and three used disposable razors in an unlabelled kidney tray in this shared washroom.

In a specified room: Inspector #573 observed two used white tooth brushes and two used tubes of tooth paste in an unlabelled kidney tray in this shared washroom.

In a specified room: Inspector #178 observed one used unlabelled tooth brush and two unlabelled denture cups on the sink counter of this shared washroom.

On August 08, 2017, during a tour of the home, the following unlabelled personal care items were observed in the tub/shower rooms:

In the second floor shower room, Inspector #178 observed one used unlabelled hair brush, one used unlabelled comb and one used unlabelled disposable razor.

In the third floor shower room, Inspector #178 observed one used bar of soap sitting on top of the soap dispenser. Small hairs were noted on the bar of soap, and an unlabelled used disposable razor was placed on top of it.

In the third floor tub room, Inspector #178 observed one unlabelled nail clipper and one used unlabelled disposable razor in the cupboard. A used unlabelled toothbrush was observed on the counter.

In the seventh floor shower room, Inspector #573 observed one unlabelled nail clipper and one used unlabelled comb on top of a cupboard.

On August 16, 2017, Inspector #573 observed one used bar of soap and one used unlabelled disposable razor with hair in the blade in the third floor shower room.

On August 17, 2017, Inspector #573 spoke with Assistant Executive Director who is the home's Infection Prevention and Control (IPAC) lead staff member. With regards to the disposable razors, the IPAC lead indicated that all the used disposable razors are to be

discarded immediately after use by the staff in a sharps container. With regards to personal care items in the shared washrooms, the IPAC lead indicated that all items should be labelled with the resident's name and stored in an appropriate manner that avoid any contamination.

2. On August 08 and 09, 2017, in a shared washroom, Inspector #178 observed a large urinary catheter drainage bag which was placed on a bath tub with no adaptor on the catheter's tubing end.

On August 16, 2017, in the shared washroom, Inspector #573 observed one leg catheter bag and one large urinary catheter drainage bag which were placed on a tub grab bar with no adaptor on the catheter's tubing end. The inspector observed that the leg bag was unclean with urine.

On August 16, 2017, Inspector #573 spoke to RPN #111 who indicated that the catheter drainage bags were used for resident #059. RPN #111 indicated that the resident's catheter bags are to be changed once a week during bath days, and she noted that the resident's catheter drainage system was not kept clean and stored in an appropriate manner. The RPN immediately discarded the urinary catheter drainage tube and the bag.

On August 17, 2017, Inspector #573 spoke with the home's IPAC lead with regards to catheter care. She indicated that nursing staff are supposed follow infection prevention and control practices while changing and cleaning the catheter drainage bags. Further she indicated that nursing staff are supposed to clean the catheter drainage bag by sterile method, close the catheter tube end with an adaptor, and store it in the catheter bin for individual resident use.

Staff members were observed to not participate in the home's infection prevention and control program, specifically related to residents' personal care items that were not properly labelled and stored in shared washrooms and tub/shower rooms, and regarding resident #59's catheter care. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care in place for resident #050 that set out the planned care for the resident.

Review of resident #050's current plan of care indicated that the resident suffers from specific medical diagnosis and exhibits responsive behaviours.

Review of resident #050's progress notes indicated that on specified dates, the resident was behaving aggressively towards staff while they provided care for the resident's roommate. A progress note on a specified date indicated that resident #050 also yelled "out" at the roommate's family when they were present in the room. A progress note on a specified date documents that the resident was verbally aggressive with staff.

Review of resident #050's Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment completed on a specified date, indicated that the resident had been assessed as exhibiting specific behaviours one to three times in the past seven days.

On August 22, 2017, Inspector #178 interviewed the DOC who indicated that during a specific month, RPN #129 reported to the home's management that resident #050 was disturbing the roommate's family, and the RPN asked for assistance to deal with the matter. The RPN also expressed concern that resident #050 had a knife in the room which family had provided for him/her to peel fruit. The DOC indicated to Inspector #178 that Clinical Manager #126 spoke with the roommate's family, and RPN #129 removed the knife from resident # 050's room. The plan was that the knife would be stored in the medication cart for safekeeping, to be given to the resident when needed, and returned to the medication cart after he/she peeled the fruit.

A written plan of care for responsive behaviours was only initiated for resident #050 on a specified date, after an incident that occurred between resident #050 and his/her roommate. A review of resident #050's written plan of care before this incident did not reveal a plan of care addressing any of resident #050's documented responsive behaviors.

During an interview with Inspector #178 on August 22, 2017, the DOC indicated that no written plan of care was initiated for resident #050's responsive behaviours until after the altercation between resident #050 and the roommate, and that a written responsive behavior plan of care should have been initiated for resident #050 when he/she began displaying responsive behaviours such as yelling at the roommate's family.

[log 010476-17] [s. 6. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #012's plan of care indicated that the resident is at risk for impaired skin integrity. The plan of care further indicated that the resident currently has altered skin integrity to a specified body part and that a specific treatment plan is in place.

Review of resident #012's progress notes indicated that altered skin integrity to a specific body part was identified on a specified date. During review of resident #012's medical record by Inspector #178, no record of a skin assessment of the area of altered skin integrity, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, could be found.

On August 17, 2017, Inspector #178 interviewed RPN #111, who indicated that she was working on the shift when the altered skin integrity was identified, and that she assessed the resident at the time, but did not do so using an assessment tool specifically designed for skin and wound assessment. RPN #111 explained that normally when a wound is identified, the registered staff uses the Wound Assessment Treatment Observation tool to assess it, however she did not use the tool in this case.

On August 17, 2017, Inspector #178 interviewed the home's Wound Care Champion (WCC). The WCC indicated that resident #012's altered skin integrity should have been assessed using the Initial Wound Assessment Tool on which the registered staff would document the size and description of the wound, and that this was not done. [s. 50. (2) (b) (i)]

Issued on this 15th day of September, 2017

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

Original report signed by the inspector.