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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 08, 2017;	2016_252513_0011 (A1)	030121-16	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Cheltenham Care Community
5935 BATHURST STREET NORTH YORK ON M2R 1Y8

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

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

JUDITH HART (513) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The following sentence in the Order Report has been removed: "The date for complying the order shall not be later than February 1, 2017."

Issued on this 8 day of February 2017 (A1)

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

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JUDITH HART (513) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 17, 18, 19, 20, 21, 24, 25, 26, 28, 31, November 1, 2, 3, 4, 2016.

The following critical incident (CI) inspections were conducted concurrently with the RQI: 002168-15 (related to abuse), 019476-15 (related to abuse), 001701-16 (related to skin and wound), 009154-16 (related to skin & wound), 035664-15 (related to abuse and responsive behaviours), 023466-15 (related to responsive behaviours), 028990-16 (related to responsive behaviours), 003169-15 (related to falls and hospitalization), 033095-15 (related to transfer and hospitalization), and 007903-14 (related to maintenance), 030804-15 (related to maintenance), and 031339-15 (related to abuse).

The following complaint inspections were conducted concurrently with the RQI: 009376-14 (related to maintenance, continence care, supply availability), 000631-15 (related to bill of rights, continence care, supply availability, plan of care, and discharge), 029101-15 (related to plan of care).

The following follow-up (FU) to a compliance order (CO) inspection was conducted concurrently with the RQI: 009958-16 (follow-up to compliance orders from 2016_398605_0005 residents bill of rights, payment/charges and individualized menus).

During the course of the inspection, the inspector(s) spoke with residents and families, executive director (ED), director of care (DOC), associate DOC (ADOC), registered nursing staff, personal support workers (PSWs), wound care nurse, director of dietary services (DDS), registered dietitian (RD), food service supervisor (FSS), dietary aide, cook, environmental services manager (ESM), director of resident programs and admissions, housekeepers, receptionist, substitute decision makers (SDMs), Residents' Council representative and Family Council president.

During the course of the inspection, the inspector(s): conducted a tour of the home; observed meal service, medication administration, resident to resident interactions, staff to resident interactions and the provision of care; reviewed resident health care records, staff training records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **13 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 3. (1)	CO #001	2016_398605_0005	501
O.Reg 79/10 s. 71. (5)	CO #003	2016_398605_0005	501
LTCHA, 2007 s. 91. (4)	CO #002	2016_398605_0005	501

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique").

On a specified date in 2015, the licensee submitted a Critical Incident Report (CIS) to the Director, reporting that an allegation of staff to resident abuse occurred. The allegation was that while PSW # 115 was providing care to resident # 023, the resident requested the PSW to come back later and refused further care. The PSW, however, continued with resident care and subsequently injured the resident while providing care.

During an interview, resident # 023 informed inspector # 116 that he/she requested PSW # 115 to come back later to provide care, which PSW # 115 refused. Resident # 023 reported that the water was not at the desired temperature and requested PSW # 115 to allow the water to get warm. The resident stated that PSW # 115 turned the dial to increase the water temperature, however, the water was not at the desired temperature and the staff continued to proceed with bathing. The resident reported that he/she brought liquid soap, but did not intend for the liquid soap to be used for bathing purposes. The resident reported that PSW # 115 proceeded to use the soap and poured the liquid over his/her head. The resident reported that he/she requested to bathe on his/her own, however PSW # 115

proceeded to bathe the resident in a hurried manner. The resident reported that PSW #115 grabbed both of his/her upper arms in a rough manner. Resident # 023 reported that he/she informed PSW # 115 that he/she would call the police, which PSW # 115 responded to go ahead and call the police.

An interview with PSW # 115 indicated that on a specified date, he/she did not recall reviewing the resident's plan of care prior to initiating care. PSW # 115 reported that while providing care to resident # 023 he/she held the arms of the resident to prevent him/her from falling. PSW # 115 reported to inspector # 116 that he/she observed an alteration in skin integrity on the resident's arms prior to the shower, however, failed to report the observations to the nurse-in-charge.

A review of the homes internal investigation notes and interviews held with the Executive Director and Director of Care (DOC) revealed that the allegations were founded. Following the home's investigation, PSW # 115 was disciplined, as the home found the care provided was inappropriate and contrary to the homes prevention of abuse and neglect policy, the Resident Bill of Rights and the homes hygiene personal care and grooming policy. The DOC confirmed that resident # 023 was not protected from abuse. [s. 19. (1)]

2. On specified date in 2015, the licensee submitted a CIS to the Director reporting that an allegation of staff to resident abuse occurred. During PSW # 148's attempt to provide care, resident # 012 covered a body part with the right hand. PSW # 148 pulled the resident's hand away to continue providing care and stated, it will be a lesson for you. Resident # 012 sustained an injury with swelling and bruising to a specific body area.

A review of the progress notes on a specified date revealed the resident had an injury with swelling to a specific body area. A review of hospital notes identified the resident sustained a specified injury.

An interview with resident # 012 revealed that at the time of the incident, the PSW was rough and rushing when providing care. The resident verbally refused to be cared for by the PSW and covered his/her her body part with a hand to indicate that care was not wanted. The PSW then pulled on the resident's body part to continue with care. The resident stated that the PSW's actions were rough and the resident sustained an injury.

An interview with RPN # 116 revealed that it was PSW # 148 who provided care for

resident # 012 that day. RPN # 116 further stated that his/her interview with the resident # 012 on a specified date revealed when PSW # 148 attempted to provide care to resident # 012, the resident refused the care and tried to push the PSW's hand away, sustaining an injury. RPN # 116 revealed that PSW # 148 no longer works in the home. Multiple attempts made by inspector # 646 to contact PSW # 148 by phone were unsuccessful. RPN # 116 stated the actions of PSW # 148 was considered abuse of the resident.

An interview with ADOC # 136 revealed that it is the home's expectation that when a resident refuses care, staff should re-approach and return later, but not to continue with care if the resident refuses. The ADOC # 136 further revealed that PSW # 148 received disciplinary actions in accordance with the company's Policies and Procedures and no longer works for the home. Interviews with the ADOC # 136 and DOC confirmed that PSW # 148 did not follow the home's expectation and should not have continued to provide care to the resident when he/she clearly indicated that he/she did not want the care. ADOC # 136 confirmed that the action of the staff resulted in an injury to the resident and was considered abuse. The severity of harm was actual. The scope of the noncompliance was isolated. A review of the home's Compliance History revealed that there were no prior notifications. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

An interview with one of resident # 045's substitute decision makers (SDMs)

revealed resident # 045 preferred not to have particular care givers attend to personal care according to personal cultural beliefs. According to the SDM, the resident would scream the whole time when a particular care giver gave personal care.

A review of resident # 045's progress notes on a specified date revealed there was a discussion between the home's previous DOC, resident relations coordinator (RRC) and one of resident # 045's SDMs. According to the family, they were assured upon admission they would accommodate the resident's preferences related to care givers. However, during this discussion, the RRC explained to the family that the home could not guarantee granting of this request due to staffing issues and sick calls.

An interview with RPN # 134 revealed he/she recalled resident # 045 did not want a particular care giver but stated due to the amount of care givers, it was not always possible to change the assignments.

A review of a complaint record found in the home's complaint binder revealed the above family discussion was documented as a complaint and that they were not satisfied. In the corrective action section of the complaint record, new management reviewed this concern and determined that the resident's preference takes precedent. The new management communicated to nursing staff that care giver preference needs to be identified in the plan of care and that it will be the RN's responsibility to adjust team assignments to accommodate a resident's preference.

An interview with ADOC # 136 revealed he/she was the manager that recorded the complaint and brought it forward to the new management in order that they would change their policy and mandate initiatives to ensure residents' preferences are upheld.

An interview with ADOC # 136 and the ED confirmed that in the above mentioned case, the home had not fully respected and promoted resident #045's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident has the right to have his or her participation in decision-making respected.

Resident # 046 was interviewed as part of a follow up to orders # 001, 002, 003

from inspection #2016_398605_0005.

A review of resident # 046's Multi Data Set (MDS) assessment revealed he/she had a cognitive performance score of three indicating moderate impairment. An interview with resident # 046 revealed he/she had never been offered to have his/her dietary preferences related to religious adherence accommodated by this home.

A review of resident # 046's progress notes, on a specific date, revealed a previous registered dietitian (RD) identified that because resident's Cognitive Performance Score (CPS) was five, contact was made to the resident's SDM in order to follow up on the resident's religious preferences. According to another progress note, on a specific date, the SDM called the RD back and stated he/she did not want resident # 046 to receive the above mentioned dietary preferences and this was not something the resident had in his/her past.

An interview with the director of dietary services (DDS) revealed he/she does not know why resident # 046 was identified to have a CPS score of five but did confirm that all residents, regardless of their CPS, should have been asked if they preferred to adhere to particular dietary preferences. An interview with the ED revealed that resident # 046 should have been asked about dietary adherence preferences and confirmed that in this case the resident's right to have his or her participation in decision-making was not respected. [s. 3. (1) 9.]

3. The licensee has failed to ensure that the resident's right to have his or her personal health information kept confidential was fully respected and promoted.

On November 2, 2016, at 1245 hours, an observation revealed there were two unlocked portable sheds in the back of the home that had multiple boxes of discharged resident files in and outside the sheds. There were no staff in attendance and this area was easily accessible to people walking by on the street. The inspector entered the home from the back and spoke with the first available manager who was the Food Service Supervisor (FSS). The FSS confirmed that resident files had been left unattended. An interview with ADOC #136 revealed that these files should not have been left accessible to people walking by and confirmed that the home had not fully respected the resident's right to have his or her personal health information kept confidential. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted; that every resident has the right to have his or her participation in decision-making respected; and that the resident's right to have his or her personal health information kept confidential, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

A review of Critical Incident Report (CIR) revealed that on a specified date, both of the home's elevators were not functioning, but no persons were stuck in either elevator. A review of a second CIR from 2015 revealed resident # 049, 051, 052 and 053 along with PSW # 142 were stuck in one of the home's elevators on another specified date, for approximately 40 minutes.

An interview with PSW # 142 revealed he/she remembers being stuck in the elevator with a full load of residents. PSW # 142 indicated that he/she, as well as the residents, were panicking and getting hot. The PSW indicated resident # 049 started crying. Interviews with residents # 049 and # 053 revealed they remembered being stuck in the elevator and were scared. An interview with

resident # 059 revealed he/she was afraid to get on the elevators each and every time because they jolt and sometimes stop in the middle of the floors and you can hear people calling out. Resident # 059 also indicated that going in the elevators caused him/her stress and anxiety that he/she did not need.

Observations on a specified date revealed the elevators were not operating normally. On this date, the door hesitated when it was opening on the second floor and the inspector was able to push it open. On a second date, the elevator did not open when it reached the second floor and continued up to the third floor even though the second floor button had been pushed. An interview with RN # 141 revealed that this happened often and was described as "the elevator taking you for a ride."

Interviews with PSW # 147 and RN # 141 revealed they do not feel confident in using the elevators. PSW # 147 described getting stuck in the elevator at least three times and one time for seven minutes. RN #141 revealed he/she always carries his/her phone with him/her as he/she is claustrophobic, fears being stuck in the elevator and feels unsafe in the elevators.

A review of complaint intake #009376-14, revealed there were problems with the elevator. An interview with resident # 045's substitute decision maker (SDM) revealed that during resident #045's stay at the home, between two specified dates, the elevators were not functioning most of the time and one time both elevators were not functioning.

Interviews with the environmental services manager (ESM) and ED revealed the elevators in the home were old and needed replacing. The ED did not feel the elevators were an immediate safety risk, but confirmed that if the residents do not feel safe, it is a situation that needs to be addressed. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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

s. 6. (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 that every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During the resident quality inspection (RQI), potential side rail restraint was triggered for resident # 005 from resident observation. Multiple observations of resident # 005's bed revealed the resident had a right quarter side rail and a left full side bed rail.

A review of the resident's current written plan of care revealed that the resident had a right quarter side rail and a left full side rail. A review of the resident's current Kardex revealed that the resident uses a right quarter side rail, but did not mention the use of a left side rail.

A review of the physician's order on a specified date, documented resident # 005 required the use of both quarter side rails as a personal assistance services device

(PASD) for bed mobility and transfer, when the resident is in bed. A review of resident's restraint/PASD assessment, on a specified date, revealed resident # 005 was assessed for the use of the right quarter and left full side rails.

An interview with RN # 133 (restraint/PASD lead) confirmed that the information regarding resident # 005's bed rail in the resident's written plan of care was unclear.

Interviews with RPN # 119, RN # 121, and RN # 133 (restraint/PASD lead) revealed the written plan of care did not set out clear directions in relation to the use of side rails to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

On a specified date in 2015, a CIS was submitted to the Director reporting alleged staff to resident abuse during bathing. This incident was inspected concurrently with the RQI.

The written plan of care for resident # 023 in effect on a specified date, documented the resident required two staff limited assistance with bathing.

A review of the resident's health record revealed and interviews with PSW # 115 and registered staff# 116 confirmed that on a specified date, PSW # 115 provided a shower to resident # 023 without the assistance of a second staff member. Further interview held with the DOC confirmed that the care set out in the plan of care related to bathing of resident # 023 was not provided as specified in the plan. [s. 6. (7)]

3. On a specified date in 2015, a CIS was submitted to the Director related to an injury sustained by resident # 026 during a transfer.

Resident # 026 was admitted to the home on a specified date, as a short-stay resident. The written plan of care created upon admission documented that the resident required two person assistance side by side for transfers and to use a mobility device during transfers.

Record review and interviews held with PSW # 144, RPN # 134 and RN # 145,

revealed that on a specified date, PSW # 146 attempted to transfer resident # 026 from wheelchair to bed without the assistance of another staff member. Upon assisting the resident to stand, resident # 026 and PSW # 146 observed blood on the floor and noticed the resident had sustained an injury. The resident was transferred to hospital for further assessment, which resulted in having specific treatment. PSW # 146 was terminated from the home and unavailable to be interviewed. Attempts made to contact PSW # 146 by phone were unsuccessful.

Interviews held with PSW # 144, RPN # 134, RN # 145 and the DOC indicated that PSW #146 failed to use safe transferring and positioning devices or techniques when assisting resident # 026. [s. 6. (7)]

4. Resident # 045 is living with multiple medical conditions and required assistance with activities of daily living, including assistance with dressing.

A review of resident # 045's progress notes on a specified date, revealed the family wanted staff to ensure that the resident was fully clothed every day and the written plan of care was updated with this information on the same day. A review of resident # 045's plan of care and interview with staff # 134 also revealed the resident did not speak English and only communicated in another language.

A review of the progress notes on on a specified date, revealed the SDM came to the nursing station and was concerned that resident # 045 was not fully clothed while lying in bed. According to the note, the resident was in bed on day shift and the SDM stated it was not acceptable for the resident not to be fully clothed even if he/she was in bed.

An interview with RPN # 134, who wrote the above mentioned progress note, indicated that resident # 045 was not fully clothed. He/she further indicated that he/she was not aware that the resident's plan of care indicated the resident should be fully clothed daily and it was not unusual for residents who are in bed to be partially dressed. An interview with RN # 140 revealed that if a resident's plan of care specified for a resident to be fully clothed every day, then even if he/she is in bed, he/she should be fully clothed.

An interview with ADOC # 136 revealed it is not the practice in the home to have residents who are in bed for the day partially dressed, unless requested. The ADOC further stated that in the above case, since the plan of care indicated the resident should be fully dressed, a note should have been documented to say why

he/she was not. An interview with the ADOC and ED confirmed that the care set out in the plan of care for the resident was not provided to resident # 045 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: 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 use safe transferring and positioning devices or techniques when assisting residents.

On a specified date in 2015, a CIS was submitted to the Director related to an injury sustained by resident # 026 during a transfer.

Resident # 026 was admitted to the home as requiring a short-stay. The written plan of care created upon admission documented that the resident required two person assistance, side by side, for transfers and to use an ambulation device during transfers.

A review of the resident's health record and interviews held with PSW # 134, RPN # 144 and RN # 145 revealed that on on a specified date, PSW # 146 attempted to transfer resident # 026 from the wheelchair to the bed without the assistance of another staff member. Upon assisting the resident to stand, resident # 026 and PSW # 146 observed blood on the floor and noticed the resident sustained an injury. The resident was transferred to hospital for further assessment, which resulted in medical treatment. PSW # 146 was not available to be interviewed.

Interviews held with PSW # 134, RPN #144, RN # 145 and the DOC indicated that PSW # 146 failed to use safe transferring and positioning devices or techniques when assisting resident # 026. [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 #6: 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 skin breakdown, pressure ulcers, skin tears or wounds, 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.

A review of a CIS, dated 2016, revealed resident # 001 was observed to have an alteration in skin integrity.

The current written plan of care indicated resident # 001 was at a high risk for altered skin integrity, required total assistance for care, turning and repositioning. An interview with registered staff # 153 revealed resident # 001 was at a high risk for poor skin integrity.

A review of the progress notes on a specified date, showed a recurrent alteration in skin integrity to a specific area and a protective dressing was applied. An interview with RN # 153 confirmed the alteration in skin integrity had deteriorated on a specified date.

The Skin Care Program specifies the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and/or wound assessment and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the assessment section of the electronic health record and progress notes did not confirm a skin and wound assessment had been completed on a specified date.

Interviews with RN # 132, RN # 153 and ADOC # 136 confirmed a skin and wound assessment was not performed using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. A review of a CIS dated 2016, indicated resident # 008 was discovered with an area of altered skin integrity to a specific area.

The written plan of care, on a specified date, for resident # 008 indicated the potential for impaired skin integrity related to incontinence, decreased mobility secondary to a medical condition and required total assistance for turning, repositioning and personal care. The resident was also identified at high risk for nutritional problems.

A review of the progress notes, on a specified date, showed a specific area was observed and was treated with medical products.

A review of the assessments and progress notes, between two dates, did not confirm a skin and wound assessment had been completed, with focus on a specific area. On a specified date a the area of altered skin integrity was observed by registered staff.

Interviews with PSW # 154 and RN # 153 revealed resident # 008 was at high risk for skin breakdown.

Interviews with ADOC # 136 confirmed a skin and wound assessment was not performed using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home and had any changes made to the plan of care related to nutrition and hydration been implemented.

A review of a CIS, dated 2016, revealed resident # 001 was observed to have an area of altered skin integrity.

The written plan of care, on a specific date, indicated resident # 001 was at a high risk for altered skin integrity, required total assistance for care, turning and repositioning.

An interview with registered staff # 153 and registered dietitian # 112 revealed resident # 001 was at a high risk for poor skin integrity.

A review of the progress notes, on a specified date, showed a recurrent area of altered skin integrity and a protective dressing was applied. An interview with registered staff # 153 confirmed this area of altered skin integrity. A dietary referral was sent to the dietitian on a specified date for the altered skin integrity. On a specified date, the area of altered skin integrity was observed to deteriorate.

Interviews with registered staff # 132, registered dietitian # 112 and ADOC # 136 revealed a dietary referral was indicated for the above deterioration in skin integrity.

Interviews with registered staff # 153, # 132, ADOC # 136 and registered dietitian # 112 confirmed the resident did not have a dietary referral for the deterioration in skin integrity. [s. 50. (2) (b) (iii)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: a) receive 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; and b) is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #7: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The licensee's policy entitled, Pain and Symptom Management (Policy# VII-G-30.10, revised January 2015) states that the Registered staff will:
1) Conduct and document a pain assessment electronically:
- on admission and re-admission
- quarterly with an MDS pain score of two or more or with significant change in status
- on initiation of a pain medication or PRN analgesic
- when there is a change in condition with pain onset
- when resident reports pain or symptoms of greater than 4/10 for 24-48 hours
- with distress related behaviours or facial grimacing
- when report from resident, family, staff/volunteers that pain is present
2) Conduct an electronic weekly pain assessment when:
- a scheduled pain medication does not relieve the pain
- pain remains regardless of the interventions

On on a specified date in 2015, the home submitted a CIS to the Director reporting an unwitnessed incident that resulted in injury to resident # 022.

A review of the resident's progress notes documents that the resident complained of pain to a specific area. Progress notes, between two dates, documented several entries where the resident was noted to complain of pain and the pain scale was greater than 4/10.

Interviews with RPN #'s 105, 108 and the DOC indicated that an electronic pain assessment and weekly pain assessment were not completed when resident # 022 continued to complain of pain as per the homes pain and symptom management policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (1) A Family Council of a long-term care home has the power to do any or all of the following:
1. Provide assistance, information and advice to residents, family members of residents and persons of importance to residents, including when new residents are admitted to the home. 2007, c. 8, ss. 60 (1), 195 (7, 8).
2. Advise residents, family members of residents and persons of importance to residents respecting their rights and obligations under this Act. 2007, c. 8, ss. 60 (1), 195 (7, 8).
3. Advise residents, family members of residents and persons of importance to residents respecting the rights and obligations of the licensee under this Act and under any agreement relating to the home. 2007, c. 8, ss. 60 (1), 195 (7, 8).
4. Attempt to resolve disputes between the licensee and residents. 2007, c. 8, ss. 60 (1), 195 (7, 8).
5. Sponsor and plan activities for residents. 2007, c. 8, ss. 60 (1), 195 (7, 8).
6. Collaborate with community groups and volunteers concerning activities for residents. 2007, c. 8, ss. 60 (1), 195 (7, 8).
7. Review,
i. inspection reports and summaries received under section 149,
ii. the detailed allocation, by the licensee, of funding under this Act and the Local Health System Integration Act, 2006 and amounts paid by residents,
iii. the financial statements relating to the home filed with the Director under the regulations and with the local health integration network for the geographic area where the home is located under the Local Health System Integration Act, 2006, and
iv. the operation of the home. 2007, c. 8, ss. 60 (1), 195 (7, 8).
8. Advise the licensee of any concerns or recommendations the Council has about the operation of the home. 2007, c. 8, ss. 60 (1), 195 (7, 8).
9. Report to the Director any concerns and recommendations that in the Council's opinion ought to be brought to the Director's attention. 2007, c. 8, ss. 60 (1), 195 (7, 8).
10. Exercise any other powers provided for in the regulations. 2007, c. 8, ss. 60 (1), 195 (7, 8).

s. 60. (2) If the Family Council has advised the licensee of concerns or

recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Family Council of a long-term care home has the power to review inspection reports and summaries received under section 149.

The Family Council questionnaire, completed by the Family Council president, revealed that a Family Council of a long-term care home has the power to review inspection reports and summaries received under section 149 and were not provided copies of the Ministry of Health and Long-Term Care (MOHLTC) public reports for review.

A review of the MOHLTC public inspection reports of the home from April 25, 2014, to the current date revealed that several public inspection reports were generated.

An interview with the Family Council president revealed the public report on a specific date, was the last MOHLTC inspection report received by the Family Council. A review of Family Council minutes for 2015 and 2016 did not reveal that MOHLTC inspection reports were reviewed. No MOHLTC reports were found in the Family Council information provided by the licensee and the Family Council president.

An interview with the present assistant to the Family Council and ED could not confirm that the Family Council had received any of the MOHLTC public inspection reports since April 2014. [s. 60. (1) 7. i.]

2. The licensee has failed to ensure that when the Family Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The Family Council questionnaire, completed by the Family Council president, revealed that when the licensee was advised of concerns or recommendations, a response in writing within 10 days from the licensee was not received by the Family Council.

The Family Council minutes of May 2016, revealed information flyers to advertise and encourage families to become involved in the Family Council were prepared with the intent to be distributed to all families via the monthly billing system. The Family Council assistant was responsible to communicate with the licensee to facilitate distribution. A response in writing was never received from the licensee by the Family Council.

The Family Council minutes of May 2016, revealed the Family Council proposed to organize and coordinate information and education sessions on Alzheimer's Disease and other topics of interest be delivered to interested family of the home's community.

An Interview with the Family Council president revealed the prior Family Council assistant reported that the parent corporation for the home had to approve such education. Approval by the licensee or parent organization did not occur. A response in writing was never received by the Family Council.

Interviews with the current Family Council assistant and ED confirmed there was no evidence that the licensee had provided written approval within 10 days of the request for information flyers to be distributed via the monthly billing system, nor that requested education had been approved in writing within 10 days. [s. 60. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

During stage one of the resident quality inspection (RQI), nutrition and hydration was triggered for resident # 007.

A review of resident # 007's current written plan of care and preferences in the dietary binder revealed the resident was to be provided a specified diet and texture and staff were to provide a dietary intervention only if the resident refused both menu options from the menu rotation.

Observations and interviews with RPN # 106, PSWs # 114 and # 123 revealed resident # 007 was not asked for meal preference and was not tried with the planned meal prior to being provided with the intervention at breakfast on October 20, 21, and 24, 25, 28, 2016.

Interviews with PSWs # 114, # 123 and RPN # 110 confirmed that the planned menu items were not consistently offered to resident #007.

Interviews with the RD and Director of Dietary Services confirmed that for resident #007, who could not communicate her meal choices, staff should have provided and tried the resident with one of the two planned menu choices before providing the intervention. The RD and DDS further confirmed that the staff did not follow the home's expectation for residents to be offered choices from the planned menus. [s. 71. (4)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care are posted in the home.

The inspector observed on October 17, 2016, that three of the required inspection reports from the past two years were not posted in the home, specifically:
• 2016_340566_0006
• 2015_398605_0020
• 2014_321501_0024

An interview with the ED confirmed the above noted public reports were not posted in the home. [s. 79. (3) (k)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

The Family Council questionnaire, completed by the Family Council president, revealed the licensee did not consult with or seek the advice of the Family Council in developing and carrying out satisfaction surveys conducted by the Long-Term Care (LTC) home.

An interview with the Family Council president revealed the licensee conducted satisfaction surveys in September of 2015 and 2016.

Interviews with the Family Council president, Family Council assistant, ED and a review of the Family Council minutes for 2015 and 2016 confirmed that in 2015 and 2016 the Family Council was not involved with developing and carrying out the home's satisfaction survey. [s. 85. (3)]

WN #12: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

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 documented record is kept in the home that includes the type of action taken to resolve the complaint, including the date of the action, and every date on which any response was provided to the complainant.

Review of complaints made to the home on two specified dates, revealed that dates were missing from the action taken to resolve the complaints and the dates on which any response was provided to the complainant.

An interview with the ED confirmed that dates were missing from the above mentioned complaint forms. [s. 101. (2)]

2. The licensee has failed to ensure that the results of the review of complaints received are taken into account in determining what improvements are required in the home.

Review of the home's 2015 Complaints Analysis revealed the home had grouped the complaints into different issues and departments. This analysis did not indicate that anything was done that took these complaints into account in determining what improvements were required in the home.

An interview with the ED confirmed that taking into account a review of complaints to make improvements in the home had not taken place previously, but was something the home will be doing in the future. [s. 101. (3)]

WN #13: 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 is retained by the licensee for at least 10 years after the resident is discharged from the home.

A record review revealed resident # 045 was discharged from the home on a specified date. An interview with ADOC #136 revealed he/she could not locate the hard copy of resident # 045's medical record. An interview with the ED revealed that as a new manager, he/she had identified that the filing system in the home needed improvement and was confident that the file was somewhere on the premises, even though the staff have searched diligently for days. The ED confirmed that the home had 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. [s. 233. (1)]

Issued on this 8 day of February 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JUDITH HART (513) - (A1)

Inspection No. / No de l'inspection : 2016_252513_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 030121-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 08, 2017;(A1)

Licensee / Titulaire de permis :
Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

LTC Home / Foyer de SLD :
Cheltenham Care Community
5935 BATHURST STREET, NORTH YORK, ON, M2R-1Y8

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

Ministère 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 Administrator / Nom de l'administratrice ou de l'administrateur : Lora Monaco

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To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The Licensee shall:

1. Develop and implement a plan to facilitate retraining of all direct care staff members on the standards of personal care to be provided to residents. The plan should include the roles and responsibilities of each staff designated to provide care related to bathing and grooming of residents.

2. Develop and implement a plan to facilitate training/retraining on the homes zero tolerance for abuse policy with focus on staff to resident abuse and neglect, and ensure all staff comply with the home's policies and procedures.

The licensee shall prepare, submit and implement a plan for complying with s.19 and identify who will be responsible for completing all of the tasks identified in the order and when the order will be complied with.

This plan is to be submitted via email to inspector: Judith.Hart@ontario.ca on or before January 23, 2017.

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

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

Grounds / Motifs :

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

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique").

2. On specified date in 2015, the licensee submitted a CIS to the Director reporting that an allegation of staff to resident abuse occurred. During PSW # 148's attempt to provide care, resident # 012 covered a body part with the right hand. PSW # 148 pulled the resident's hand away to continue providing care and stated, this will be a lesson for you. Resident # 012 sustained an injury with swelling and bruising to a specific body area.

A review of the progress notes on a specified date revealed the resident had an injury with swelling to a specific body area. A review of hospital notes identified the resident sustained a specified injury.

An interview with resident # 012 revealed that at the time of the incident, the PSW was rough and rushing when providing care. The resident verbally refused to be cared for by the PSW and covered his/her body part with a hand to indicate that care was not wanted. The PSW then pulled on the resident's body part to continue with care. The resident stated that the PSW's actions were rough and the resident sustained an injury.

An interview with RPN # 116 revealed that it was PSW # 148 who provided care for resident # 012 that day. RPN # 116 further stated that his/her interview with the resident # 012 on a specified date revealed when PSW # 148 attempted to provide care to resident # 012, the resident refused the care and tried to push the PSW's hand away, sustaining an injury. RPN # 116 revealed that PSW # 148 no longer works in the home. Multiple attempts made by inspector # 646 to contact PSW # 148 by phone were unsuccessful. RPN # 116 stated the actions of PSW # 148 were

considered abuse of the resident.

An interview with ADOC # 136 revealed that it is the home's expectation that when a resident refuses care, staff should re-approach and return later, but not to continue with care if the resident refuses. The ADOC # 136 further revealed that PSW # 148 received disciplinary actions in accordance with the company's Policies and Procedures and no longer works for the home. Interviews with the ADOC # 136 and DOC confirmed that PSW # 148 did not follow the home's expectation and should not have continued to provide care to the resident when he/she clearly indicated that he/she did not want the care. ADOC # 136 confirmed the actions of the staff resulted in an injury to the resident and was considered abuse. The severity of harm was actual. The scope of the noncompliance was isolated. A review of the home's Compliance History revealed that there were no prior notifications. [s. 19. (1)] (646) (646)

2. On a specified date in 2015, the licensee submitted a Critical Incident Report (CIS) to the Director, reporting that an allegation of staff to resident abuse occurred. The allegation was that while PSW # 115 was providing care to resident # 023, the resident requested the PSW to come back later and refused further care. The PSW, however, continued with resident care and subsequently injured the resident while providing care.

During an interview, resident # 023 informed inspector # 116 that he/she requested PSW # 115 to come back later to provide care, which PSW # 115 refused. Resident # 023 reported that the water was not at the desired temperature and requested PSW # 115 to allow the water to get warm. The resident stated that PSW # 115 turned the dial to increase the water temperature, however, the water was not at the desired temperature and the staff continued to proceed with bathing. The resident reported that he/she brought liquid soap, but did not intend for the liquid soap to be used for bathing purposes. The resident reported that PSW # 115 proceeded to use the soap and poured the liquid over his/her head. The resident reported that he/she requested to bathe on his/her own, however PSW # 115 proceeded to bathe the resident in a hurried manner. The resident reported that PSW # 115 grabbed both of his/her upper arms in a rough manner. Resident # 023 reported that he/she stated to PSW # 115 that he/she would call the police, to which PSW # 115 responded to go ahead and call the police.

An interview with PSW # 115 indicated that on a specified date, he/she did not recall reviewing the resident's plan of care prior to initiating the care. PSW # 115 reported that while providing the care to resident # 023 he/she held the arms of the resident to prevent him/her from falling. PSW # 115 reported to inspector # 116 that he/she observed an alteration in skin integrity on the resident's arms prior to the shower, however, failed to report the observations to the nurse-in-charge.

A review of the homes internal investigation notes and interviews held with the Executive Director and Director of Care (DOC) revealed that the allegations were founded. Following the home's investigation, PSW # 115 was disciplined, as the home found the care provided was inappropriate and contrary to the homes prevention of abuse and neglect policy, the Resident Bill of Rights and the homes hygiene personal care and grooming policy. The DOC confirmed that resident # 023 was not protected from abuse.

The severity of harm was actual. The scope of the noncompliance was isolated. A review of the Compliance History revealed that there were no prior notifications. [s. 19. (1)] (116)
(116)

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

Feb 10, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 8 day of February 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JUDITH HART - (A1)

Service Area Office /
Bureau régional de services : Toronto