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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2019	2019_643111_0002	003325-18, 006357-18, 008122-18, 008678-18, 009199-18, 009678-18, 012875-18, 014307-18, 016487-18, 016749-18, 017787-18, 019121-18, 025567-18, 025571-18, 025573-18, 025721-18, 030661-18, 000500-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 Hope Street South PORT HOPE ON L1A 2M8

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

LYNDA BROWN (111), KARYN WOOD (601), PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 21, 22, 24, 25, 28-31, February 1, 4, 5, 8 and 11, 2019. On January 23, February 6 and 7, 2019 an off-site inspection was conducted.

There were 18 complaints completed concurrently during this inspection as follows:
-Log # 016749-18, 025567-18, 016487-18, 019121-18 and 025573-18 for heat related complaints.
-Log # 012875-18 related to falls.
-Log # 014307-18, 003325-18 and 025571-18 related to alleged resident to resident abuse.
-Log # 030661-18, 009199-18, 025721-18 and 000500-19 related to alleged staff to resident abuse.
-Log # 008122-18, 009678-18, 017787-18 and 008678-18 related to staffing and infection control.
-Log # 006357-18 related to RN coverage.

In addition, there was non-compliance related to Log # 012875-18 and will be identified under the critical incident inspection #2019_591623_0001.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance staff, Scheduling Clerk (SC), former Acting Director of Care's (A-DOC), former acting ED, Activity Aide, Environmental Manager (EM), residents, Physiotherapist and Physiotherapist Assistant.

During the course of the inspection, the inspector(s): observed residents, observed resident rooms, observed medication administration, observed meals, reviewed resident health records, reviewed employee records, reviewed staff training records, reviewed temperature logs and reviewed the following policies: complaints and customer service, zero tolerance of abuse and neglect, hot-weather , odours and air temperatures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **2 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	Légende 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 :

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

Review of the licensee's policy Zero Tolerance of Resident Abuse and Neglect (RC-02-01-01, RC-02-01-02 and RC-02-01-03), updated April 2017, indicated in (RC-02-01-02):
-page 2 of 5, the Administrator or designate: immediately initiate an investigation of the alleged, suspected or witnessed abuse.
-page 3 of 5, ensure the safety of, and provide support to the abuse victim, through completion of full assessments, a determination of resident needs and a documented plan to meet those needs.
-page 4 of 5, any employee or person who becomes aware of an alleged, suspected or witnessed resident indicate of abuse or neglect will report it immediately to the Administrator/designate/reporting manager.
(RC-02-01-03): page 1 of 5, all reported incidents of abuse and/or neglect will objectively, thoroughly and promptly investigated. On page 3 of 5, in cases where the allegation of abuse or neglect is made against an employer, management will: immediately advise the employee that they are being removed from the work schedule, with pay, pending the investigation; during the investigation, the investigating manager/supervisor will: maintain the security and integrity of the physical evidence at the site of incident fully investigate the incident and complete the documentation of all known details in keeping with the steps outlined in the investigation toolkit. See National Workplace Investigation Toolkit-Appendix 2. Under Appendix 2, Step 1: consulting company policies, procedures and standards. Collect employee statements. Prior to the start of your interviews, create a list of all witnesses who have direct or indirect knowledge of the incident.

Related to Log #025721-18:

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, a family member of resident #004 reported RN #102 was abusive to the resident. The CIR was completed by the former acting Executive Director (ED) #106 and RN #104, who was the former acting DOC.

Review of the health record for resident #004 and review of the investigation into the allegation of staff to resident abuse for resident #004 indicated:
-On a specified date and time, RN #102 had assisted a family member with a transfer of resident #004 and provided continence care. After care was provided, the family alleged the RN was abusive. Later in the shift, the family reported to the RN again that they had

been abusive to the resident. RN #102 apologized and then called the manager (RN #105 who was the former acting ED) to report the allegation.
-RN #105 no longer worked in the home, but the investigation indicated RN #104 (former acting DOC) was also involved in the investigation.
-The day after the allegation was reported, the investigation was initiated after the family were contacted and confirmed the allegation of staff to resident abuse.
-The only staff member interviewed was RN #102. There was no documentation related to the family interview. There were no interviews of any other staff who were working when the incident occurred.
-On a specified date, the investigation was concluded as founded and appropriate actions were taken to prevent a recurrence.

During an interview with the Executive Director (ED) by Inspector #111, the ED indicated that RN #102 received disciplinary action as a result of the allegation of staff to resident abuse involving resident #004 that occurred on a specified date. The ED indicated they were not working when the incident occurred, was covered by acting ED (#106) and the former ED no longer worked in the home. The ED also indicated that acting DOC (#105) was also in place at the time of the incident but no longer works in the home.

During an interview with RN #102 by Inspector #111, the RN indicated on a specified date and time, a family member of resident #004 was requested assistance with a transfer of resident #004 and with continence care. The RN indicated they were busy that shift as they were short staffed and the PSWs were busy in the dining room at the time. The RN indicated they initially told the family they would have to wait until after the meal but then assisted the family member with the resident. The RN indicated the family member then alleged the RN was abusive with the resident. The RN confirmed awareness that the resident was a two staff assistance with all personal care and should not have transferred the resident with a family member. The RN indicated the family member later the same day, again complained that the RN was abusive to the resident. The RN indicated that they apologized to the family, documented the incident in the progress notes and then notified the acting ED (#106) of the incident and the allegation. The RN indicated the ED reminded the RN to always use two staff for transfers and continued to work the remainder of their shift. The RN indicated they came in to work the following day and halfway through their shift, the management informed the RN that they were relieved of duty pending the investigation.

During an interview with RN #104 by Inspector #111, the RN indicated they were acting DOC during the time of the incident, as the DOC was on a medical leave. The RN

indicated resident #004 had advanced dementia and requires two staff assistance with transfers and continence care. The RN indicated RN #102 did notify the acting ED #106 the same day of the incident and allegation. The RN confirmed that the investigation was not completed until the following day, when the family was contacted and confirmed the allegation. The RN indicated they were not directly involved in the investigation. The RN indicated no awareness of any other staff being interviewed regarding the incident when the incident occurred.

The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with as, they failed to ensure there was complete documentation of all known details in keeping with the steps outlined in the investigation toolkit, as an interview with the family was not documented. According to the National Workplace Investigation Toolkit-Appendix 2. Under Appendix 2, Step 1: create a list of all witnesses who have direct or indirect knowledge of the incident and collect employee statements, was not completed as all staff who were working (i.e. the PSW's) were not interviewed or statements obtained, only RN #102 and in cases where the allegation of abuse was made against an employee, management was to immediately advise the employee that they are being removed from the work schedule, and RN #102 continued to work until the following day when the investigation was initiated.

2. Related to Log #000500-19:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, resident #005 had reported to RPN #103 that resident #004 had been abusive to the resident. RPN #103 reported the allegation to RN #102. The CIR was completed by the former acting DOC (#105).

Review of the investigation into the allegation of resident to resident abuse that occurred by resident #004 towards resident #005 indicated:
-The acting DOC #105 no longer works in the home and unable to interview.
-The investigation did not have any interviews of any residents or any other staff that were working (i.e. RPN#103) and only a written statement was received by RN #102.
-The investigation was concluded on a specified date and actions were taken (related to RN #102) but no indication of an outcome related to the resident to resident alleged abuse incident.

Review of the progress notes for resident #004:
-On a specified date and time, RN #102 indicated resident #005 reported to RPN #103 that resident #004 had abused the resident, could not indicate where the incident occurred and indicated the incident was un-witnessed.
-the following day, RN #102 indicated they contacted the SDM about the alleged incident and the SDM was updated on the incident from yesterday. RN #104 indicated, monitoring of resident due to allegation of abuse by co-resident #005 yesterday. Every 15 minute monitoring initiated.

Review of the progress notes for resident #005 indicated there was no documentation on the specified date related to the incident.

During an interview with RN #102 by Inspector #111, the RN confirmed on a specified date and shift, that resident #005 informed RPN #103, that resident #004 had been abusive towards them, and then the RPN reported the incident to the RN. The RN indicated that since the incident was not witnessed, the incident did not need to be reported to anyone. The RN confirmed they did not assess resident #005 or investigate the incident to determine details surrounding the incident. The RN indicated the following day, they reported the incident to the acting DOC at morning report and after the RN completed working their shift, they received a call regarding the allegation and was informed at that time that they were off work pending the investigation.

Interview with RPN #103 by Inspector #111, the RPN indicated on a specified date and time, there were at the nursing station where resident #004 was also present. The RPN indicated a PSW then reported that resident #005 reported to them, that resident #004 had been abusive to the resident. The RPN was unable to recall which PSW reported the allegation. The RPN indicated they asked resident #005 where they were struck but the resident was unable to recall. The RPN confirmed they did not document the alleged incident in either resident's health record but reported the allegation to RN #102. The RPN indicated they were asked about the incident the following day, by the former acting DOC (#105).

The licensee failed to ensure the policy that promotes zero tolerance of abuse and neglect was complied with as, there was no documentation in resident #005's health care record regarding the incident and no indication the resident was assessed. All staff who were present or aware of the incident (PSW and RPN) were not interviewed and/or statements obtained. RN #102 was made aware of an alleged resident to resident abuse, by resident #004 towards resident #005 and did not immediately report it to the

Administrator, designate or reporting manager or assess the resident.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Log #025721-18:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident abuse incident that occurred the day before at a specified time. The CIR indicated the family of resident #004 alleged RN #102 was abusive to resident

#004. The CIR was completed by the former acting Executive Director (ED) #106 and former action DOC (RN #104).

Related to Log #000500-19:

A second critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident that occurred the day before at a specified time. The CIR indicated resident #005 alleged resident #004 was abusive to the resident and reported the allegation to RPN #103 who reported the allegation to RN #102. The CIR was completed by the former acting DOC #105.

Review of the progress notes for resident #004 indicated:
-On a specified date and time, RN #102 documented that the resident's family member wanted the resident transferred back into bed, provided continence care and repositioned in bed. The RN explained to the family that the resident required two staff assistance and that transferring the resident back to bed would have to wait until the meal was over as the other staff were in the dining room assisting with the meal. The RN indicated they ended up transferring the resident into bed with family member assistance but during the transfer, the resident was asleep/very difficult to move and the family member was unable to assist with the lift. The resident was incontinent and was also changed. The RN indicated the resident would require two staff to reposition in bed and would be assisted by staff when the lunch meal was over. The family member then indicated they thought the RN was " too rough". The family member then left the home. Later the same day, the RN had to call the family member to report a different issue and the family member again alleged the RN was too rough with the resident. The RN apologized to the family member and notified the acting ED #106 of the allegation. There was no indication the Director was notified.
-On a specified date and time, RN #102 documented that resident #005 reported to RPN #103, that resident #004 had punched the resident and the incident was unwitnessed. There was no indication the Director was notified.

During an interview with RN #102 by Inspector #111, the RN indicated on a specified date, they were busy that day because they were short staffed and the PSWs were busy in the dining room with the meal. The RN indicated they initially told the family they would have to wait until after the meal for staff assistance, but the family insisted, so both the RN and the family member attempted to transfer the resident back to bed. The RN indicated after the transfer and continence care provided to the resident, the family member accused the RN of 'being too rough' with the resident. The RN confirmed

awareness that the resident was a two person assist with all personal care and should not have transferred the resident without another staff member. The RN indicated they reported the allegation to the acting ED (#106) later the same day. The RN confirmed they did not report the allegation to the Ministry of Health (MOH) because they assumed the acting ED would have reported the incident. The RN indicated the alleged resident to resident abuse incident involving resident #004 and #005 that occurred on a specified date, was initially reported to RPN #103, who reported the incident to the RN. The RN confirmed that they did not report the alleged resident to resident abuse incident to the Ministry of Health (MOH) because the incident was not witnessed.

During an interview with the current DOC by Inspector #111, the DOC confirmed they started working in the position the day after the alleged resident to resident abuse incident, involving resident #004 and #005 occurred. The DOC indicated they were present during the investigation that included the current ED, the investigation occurred the same day they started, but they were just as 'an observer'.

During an interview with RN #104 (former acting DOC) by Inspector #111, the RN indicated they were acting DOC when a previous incident occurred on another specified date. The RN indicated they also had an acting ED (#106) at the time, but no longer works in the home. The RN indicated RN #102 had assisted the family member of resident #004 with the transfer of the resident, provided continence care to the resident and the family member then expressed concern with how the resident was treated. The RN confirmed the acting ED (#106) was notified at the time of the incident and allegation. The RN confirmed the MOH was not informed of the allegation until the day after, when the acting ED reported the incident.

During an interview with the Executive Director (ED) by Inspector #111, the ED confirmed both incidents were not immediately reported to the Director, until the day after the allegations were made.

The licensee failed to ensure an alleged staff to resident abuse incident that occurred on a specified date and a second alleged resident to resident physical abuse incident that occurred on a specified date, was immediately reported to the Director as they were both reported the day after the allegations were made.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff, was on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

Under O.Reg. 79/10, s. 45(1) The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required:
2.For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,
i.in the case of a planned or extended leave of absence of an employee of the licensee who is a registered nurse and a member of the regular nursing staff, a registered nurse who works a the home pursuant to a contract or agreement with the licensee and who is a member of the regular nursing staff may be used,
ii.in the case of an emergency where the back-up plan referred to in clause 31(3)(d) of this Regulation fails to ensure that the requirement under subsection 8(3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employee agency or other third party may be used.

Related to Log # 006357-18:

An anonymous complaint was received by the Director indicating the home was using RPNs in the role of RNs.

During an interview with the Executive Director, the ED indicated the home had a master staffing plan for RNs which indicated the date/shift they worked and unit assignment schedule, which indicated which floor the staff member worked on. The ED indicated the process for indicating when the staff called in sick for their shift, the staff member was to be marked on the master schedule and also indicated on the sick call log, to clearly indicated which staff called in and the replacement. The ED indicated while the ED was on a leave, the previous acting ED #106 was directed to discontinue that practise by Extendicare. The ED confirmed they were on a leave for a three month period and was covered by the another acting ED, who no longer works in the home. The ED indicated the current DOC has only been working in the home for two weeks. The ED indicated the previous DOC position was filled by RN #104 and RN #105. The ED indicated that RN #105 went off on medical leave during the fall, was covered by RN #104 and no longer works in the home. The ED indicated the home currently had no RN vacancies and had no concerns related to RN coverage. The ED indicated if they were short an RN, the home's back up plan included the use of agency RNs or the use of either the DOC or ED (who is an RN), who would come in to cover the shift.

During an interview with the Nursing Scheduling Clerk by Inspector #111, the NSC indicated they were not aware of any shifts when there was no RN coverage in the building. The NSC indicated the previous scheduling clerk no longer worked in the home. The scheduling clerk indicated they had an attendance record and agency sign in record to indicate which RN staff were working in the home.

Review of the RN staffing schedule for 2018 indicated the following:
-RN #104 was in the acting DOC position over a specified period.
-RN #105 was in the acting DOC position over a specified period.

Review of the RN master staffing schedule, the unit assignments, the sick call log, the attendance record and the agency sign in sheets indicated there were no RN's in the building on the following dates/shifts in 2018:
-January: there were five specified dates and six specified shifts.
-March: there were two specified dates and shifts.
-April: there was one specified date and shift.
-May: there was three specified dates and shifts.

-June: there was one specified date with half a shift.
-September: there was one specified date and shift.
-October: there was three specified dates and shifts.
-November: there was two specified dates and shifts.

In addition, there were ongoing inconsistencies with the RN scheduling (master staffing plan, unit assignments and the attendance records) to clearly indicate which RN was working, for which shift. For example, on a specified date and shift, the master staffing plan indicated RN #102 was working, the unit assignment indicated an agency RN was working and the attendance record indicated RN #137 was working.

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

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, on duty and present in the home at all times, except as provided for in the regulations. 2007, c.8, s.8(3), to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

Related to Log #030661-18, Log #025721-18 and Log #000500-19:

An anonymous complaint was received regarding RN #102 who was involved in resident abuse.

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, a family member of resident #004 reported RN #102 was abusive to the resident. The CIR was completed by the former acting Executive Director (ED) #106 and RN #104, who was the former acting DOC.

A second critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, resident #005 had reported to RPN #103 that resident #004 abused the resident. RPN #103 reported the allegation to RN #102. The CIR was completed by the former acting DOC #105.

Review of the investigation into the allegation of staff to resident abuse that occurred

towards resident #005 by resident #004 indicated:
-On a specified date, RN #105 (former acting ED) was notified by RN #102 of an allegation of staff to resident abuse by RN #102 towards resident #004. RN #105 no longer worked in the home, but the investigation indicated RN #104 (former acting DOC) was also involved in the investigation.
-On a specified date (the day after the allegation was reported), the investigation was initiated, after the family were contacted and confirmed the allegation of staff to resident abuse.
-On a specified date, the investigation was concluded to be founded and appropriate actions were taken.

Review of the investigation into the allegation of resident to resident abuse that occurred by resident #004 towards resident #005 indicated:
-The acting DOC (#105) no longer works in the home and unable to interview.
-There was no documentation in resident #005 health care record on the specified date, regarding the allegation until three days later, indicating the resident was assessed related to 'an incident'.
-The investigation did not have any interviews of any residents and only RN #102 was interviewed.
-The investigation was concluded on a specified date, actions were taken related to RN #102, but there was no indication of an outcome related to the resident to resident alleged abuse incident.

Review of the progress notes for resident #004 indicated:
- On a specified date and time, RN #102 documented that the resident's family member wanted requested assistance to transfer the resident back into bed and provide continence care. The RN indicated they transferred the resident into bed on their own. The family member then alleged the RN was abusive with the resident. The RN indicated that they did not feel they were abusive with the resident. Later the same day, the RN had to call the family member for another issue and the family member again alleged the RN was too rough with the resident. The RN apologized to the family member. The RN then called the acting ED #106 to report the allegation.
-On a specified date and time, RN #102 documented that resident #005 reported to RPN #103, that resident #004 had been abusive the resident but could not tell RPN #103 where the resident was abused and was unwitnessed.

During an interview with RN #104 by Inspector #11, the RN indicated they were acting DOC during the time of the incident that occurred. The RN confirmed that RN #102

notified the acting ED (#106) the same date the allegation was received. The RN confirmed that the investigation was not completed until the following day, after the family was contacted and confirmed the allegation of staff to resident abuse by RN #102.

During an interview with RN #102 by Inspector #111, the RN indicated on a specified date, during the meal, the family member of resident #004 was requesting assistance to transfer the resident to bed and with continence care. The RN indicated they assisted the family with the transfer of the resident to bed and then provided continence care. The RN indicated after care was provided to the resident, the family member accused the RN of being abusive with the resident. The RN indicated the family again alleged they had been abusive to the resident later the same day. The RN indicated that they apologized to the family member, documented the incident in the resident's progress notes and then notified the acting ED (#106) regarding the incident and the allegation. The RN indicated they came into work the following day and halfway through their shift, they were relieved of duty pending an investigating into the incident that the RN had reported to the ED the previous day. The RN indicated on a specified date, resident #005 reported to RPN #103 that resident #004 had abused the resident and RPN #103 reported the allegation to the RN. The RN indicated because the incident was not witnessed, they did not investigate the incident. The RN indicated the following day, the RN was working a day shift and reported the incident at the morning nursing management meeting, where the former acting DOC (#105) and RN #104 were present. The RN indicated they continued to work the remainder of their shift and they received a phone call later the same day that the RN was being relieved of duty pending an investigating into the alleged incident that occurred.

During an interview with the Executive Director (ED) by Inspector #111, the ED indicated all the investigations into alleged abuse were kept in the DOC's office and would have to retrieve the investigations from the DOC.

During an interview with the DOC by Inspector #111, the DOC confirmed they started working in the position, the day after the second alleged abuse incident occurred. The DOC indicated they were 'just to be an observer during the investigation' into the alleged resident to resident abuse incident that occurred, involving resident #004 and #005. The DOC indicated the former acting DOC (#105) and the current ED were also present during the investigation. The DOC confirmed the investigation notes provided indicated the investigations occurred the day after the allegations were made.

The licensee failed to ensure an alleged staff to resident abuse incident that occurred on

a specified date and a second alleged resident to resident abuse incident that occurred on a specified date, was immediately investigated.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incidents of (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan (a) provided for a staffing mix that is consistent with the residents assessed care and safety needs, (b) set out the

organization and scheduling of staff shifts, (c) promoted continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, (d) included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) and (e) got evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

There were six anonymous complaints received over an eight month period, related to staffing concerns as follows:
1) Log #008678-18: complaint received regarding the lack of staff in the home and the residents not receiving the required care.
2) Log #009199-18: complaint indicated resident #013 waited a specified period of time, to be toileted due to short staffing.
3) Log # 009678-18: complaint indicated resident #012 sustained a fall during a transfer with staff who was rushing due to short staffing, on a specified date and call bells were not being answered in a timely manner, long wait times for toileting and assistance with dressing due to short staffing.
4) Log # 025567-18: complaint received regarding residents having to wait a specified period of time, to be toileted and a resident fell as a result of short staffing.
5) Log # 025573-18: complaint received regarding the home is always running short of staff.
6) Log # 030661-18: complaint indicating the home is always working short staffed. Resident #001 had to wait to be put back to bed due to the short staffing.

The home has 97 beds, 46 beds on second floor and 51 beds on the third floor. The staffing mix indicated there was the same staffing mix working on both the second and third floors; with a specified number of full time PSWs working on each floor, for each shift.

Review of the staffing schedule with the Nursing Scheduling Clerk (NSC) was completed by Inspector #111 for the year of 2018 and showed the following:
- During the month of January 2018, there was a total of 27 PSW full shifts not replaced.
- During the month of February 2018 there was a total of 20 PSW full shifts not staffed
- During the month of March 2018 there was a total of 17 PSW full shifts not staffed
-During the month of April 2018 there was a total of 10 PSW full shifts not staffed
- During the month of May 2018 there was a total of 20 PSW full shifts not staffed
- During the month of June 2018 there was a total of 19 PSW full shifts not staffed
- During the month of July 2018 there was a total of 22 PSW full shifts not staffed

- During the month of August 2018 there was a total of 16 PSW full shifts not staffed
- During the month of September 2018 there was a total of 7 PSW full shifts not staffed
- During the month of October 2018 there was a total of 8 PSW full shifts not staffed
- During the month of November 2018 there was a total of 12 PSW full shifts not staffed
- During the month of December 2018 there was a total of 23 PSW full shifts not staffed

During an interview with the Nursing Scheduling Clerk (NSC) by Inspector #111, the NSC indicated they have been working in the position since a specified date. as the previous NSC no longer works in the home. The NSC indicated they were aware of several dates where the home was working short with PSWs and indicated it usually occurred on specified shifts and floors. The scheduling clerk indicated the home has a master schedule for PSWs but the master schedule does not indicate which floor they work on as they are required to work on any floor. The NSC indicated the unit assignments indicate which staff, which floor and which shift the staff are working on. The NSC indicated they also have a sick call log that staff are to record who called in sick, date, shift and who they were replaced with. The NSC indicated there is also an electronic staffing record that indicates who actually came in to work. There are also is a BSO PSW, restorative care aide PSW or the incontinence/laundry aide PSW. The NSC indicated on a specified date, they were directed to discontinue marking any staff call-ins on the master schedule and only indicate on the unit assignments and sick call logs. The NSC confirmed the home frequently used agency staff to replace staff shortages and was indicated on the agency sign in sheets. The NSC confirmed the scheduling of PSW staffing was inconsistent between the master schedule, unit assignments, sick call log and the staffing record.

During an interview with RPN #103 by Inspector #111, the RPN indicated they are constantly working short staffed with PSWs, especially on a specified shift The RPN indicated it frequently results in call bells and toileting being delayed or baths not getting completed. The RPN indicated the previous weekend, there were two residents (including resident #001) who did not receive their bath due to staff not working at full-staffing. The RPN indicated the BSO and/or laundry aide PSW is only usually used to assist with a lift or answer a call bell. The RPN indicated the BSO and/or laundry aide PSW is not utilized to replace the staff shortage on the floor. The RPN indicated the previous week, the BSO staff member was pulled from their duty for only one hour to assist on the floor when they were working short staffed. The RPN indicated they have never seen any management staff assisting on the floor.

During an interview with resident #001 by Inspector #111, the resident indicated the

home was working short-staffed, especially on a specified shift, which resulted in their care not provided in a timely manner and the resident had to wait to be put to bed. The resident was unable to indicate when this occurred. The resident indicated the short staffing also resulted in call bells not being answered, toileting or assistance with care not provided to other residents for a long time. During an interview with resident #001 on a different date, by Inspector #111, the resident indicated that there were no showers completed on a specified date and time, on a specified unit because they were short staffed again.

Review of the progress notes for resident #001 indicated on a specified date and time, the resident "appeared to be upset this shift", informed the PSW that they did not get the help into bed from staff. On another specified date and time, RPN #103 indicated the resident missed their bath this weekend related to staffing concerns , noted on bath shift report for both days and noted in day planner to pick up any of the missed baths if able. The resident also voiced some frustration related to staffing.

During an interview with PSW #118 by Inspector #111, the PSW indicated they work on both floors and they have ongoing short-staffing on both floors. The PSW indicated they have never seen any management assisting on the floors when they are working short-staffed. The PSW indicated they were short-staffed on a specified date and shift again. The PSW indicated they were able to get all the baths/showers completed but by the time they were all done the baths/ showers, there were a number of residents not put to bed at the end of the shift, that needed to be assisted to bed by the staff on the next shift.

During an interview with PSW #122 (restorative care aide) by Inspector #111, the PSW indicated they have never been pulled from the regular duties to work on the floor when they are working short-staffed. They indicated they usually work on a specified floor and noted the previous weekend "was bad" as they were working short PSW's the whole weekend, on all shifts.

During an interview with RPN # 121 by Inspector #111, the RPN indicated the home is constantly working short- staffed with PSWs. The RPN indicated a specified shift is usually the worst because then they only have a specified number of PSWs to provide care to residents, which means either baths/showers do not get completed, or call bell responses are delayed and bedtime care is not provided, until a long period of time. The RPN indicated they are not able to provide much assistance as they are required to administer the medications and complete treatments. The RPN indicated they have never seen any management or other PSWs (restorative/laundry/BSO) put in

replacement of the PSWs who call in.

During an interview with PSW #132 by Inspector #111, the PSW indicated they are working short-staffed almost daily. The PSW indicated on a specified shift, they are frequently working short-staffed and they don't always have time to get resident baths completed. The PSW indicated they try to go as fast as they can but they can't always answer the call bells when they are short staffed.

During an interview with PSW #127 by Inspector #111, the PSW indicted they are frequently working short staffed on a specified shift and it is worse on the weekends. The PSW indicated we get the care completed for the residents but it is sometimes very late by the time all the care is provided.

During an interview with the Executive Director (ED) by Inspector #111, the ED indicated that they were aware of PSW shortages in the home, they have tried to replace but staff just either don't show for work or do not want to come in to work. They have also had to rely more frequently on agency for PSW's. The ED indicated while they were off on sick leave, Extendicare had them discontinue marking call-ins on the master schedule (on a specified date), which made it more confusing to determine staffing needs. The ED indicated that usually when a PSW called in sick, they would also utilize the restorative care aide, incontinence or laundry aide to back fill the shifts. During an interview with the ED on a separate date, the ED indicated the home had a master staffing plan for all staff. The ED indicated when they are working short-staffed with PSWs, they are to pull the BSO PSW or the incontinence PSW to work on the floor. The ED indicated they also would utilize the Program Manager, Dietary Manager, DOC or the ED to assist on the floors with meals or receiving calls. The ED indicated they had a recent discussion regarding a review of the staffing but had no documentation regarding the review and was unable to locate any policy relating to staffing plans. The ED indicated the process for indicating when the staff called in for their shift, was marked on the master schedule and also indicated on the sick call log who replaced the staff. The ED indicated while the ED was on sick leave, the previous acting ED was directed to discontinue that practise by Extendicare.

The provision of resident care and resident safety are compromised when staff are not being replaced. The organization and scheduling of staff shifts was unclear and there were several inconsistencies noted between the master staffing list and unit assignments (the master staffing list indicated that specified PSWs were working but unit assignment or staff record report did not have those same staff working). The sick call logs were also

not accurately reflected on either the master staffing list or the unit assignments, as staff who called in sick, were not always indicated on the master staffing plan or unit assignments (i.e on a specified date, on a specified floor, there was no indication that one PSW on a specified shift and one on a different specified shift had called in sick and was not replaced, despite the sick call log indicating such). In addition, the unit assignments provided, had up to five different versions of the same week, with each version indicating different staff working the same shifts. The sick call logs for 2018 also indicated a high number of dates where the home was consistently work short-staffed with PSWs. There was also indication that continuity of care was not minimized as several of the full-time PSW staff, worked on two specified floors and there was a high number of days/week with the use of agency staff for both RNs and PSWs on two floors and on all three shifts. For example, the week of a specified date, on a specified shift on a specified floor, there were seven out of ten shifts for PSWs where agency PSWs were utilized. In additional, there were two shifts the same week, when the specified shift was working short-staffed (only one PSW and one RPN) to assist with care for residents. There were five out of seven days agency RNs were utilized out of seven days on the day shift for the same floor.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that is consistent with the residents assessed care and safety needs, set out the organization and scheduling of staff shifts, promoted continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work and got evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

2. Related to Log # 017787-18:

An anonymous complaint was received indicating that care was not being provided to residents due to short staffing.

Review of the progress notes for resident #002:
-on a specified date and time, RN #102 informed the resident in the morning that they would have to remain in bed for breakfast due to being short staffed and not having time to get the resident up for breakfast. The RN indicated a tray would be brought to the resident. When the breakfast tray was brought to the resident, the resident refused breakfast. A few minutes later, it was reported that resident was crying and wanted to get

up out of bed.
-Approximately a week later at a specified time, the nurse indicated that "due to staffing shortages, unable to complete resident's routine bath" and notified the acting ED.
-The following day at a specified time, the resident was observed crying and reported that the agency PSW in the morning did provide proper hygiene and as per the resident's preferences. The nurse met with the agency PSW who provided morning care. The PSW apologized and confirmed the residents morning care was not provided, as per resident plan of care. After the nurse reviewed the residents care plan, the nurse noted that it was also the resident's preference, not to have any agency staff provide care.
-On a specified date and time, resident's bath was not completed this shift related to it being too late to complete the bath.
-On a specified date and time, the family called the home to express concerns that the resident was not offered their meal. The RPN indicated the resident was offered but refused. The family member indicated the resident refused their meal because they were still in their pyjamas and didn't want to go down to the dining room in pyjamas. The family requested to speak to RN #104.
-The following day, at a specified time, the family called and expressed concerns related to residents care to RN #104. The family member indicated, when they were in visiting, they noted a strong urine odour, noted the resident had not received continence care and the mobility aide was also saturated with urine. The family member indicated they wanted to ensure staff were toileting/checking the resident routinely. Staff were directed to document every shift on frequency of toileting. The family also expressed concern from the day before when the resident was left in their night clothes until the afternoon and the resident was upset. The staff explained to the family member the delay in bathing was because they were down one PSW on the unit and staff would be directed to ensure that the resident is appropriately dressed for the day.
-On a specified date and time, the family was in to visit and expressed concerns regarding the resident still having agency PSW's assigned to provide the residents care. The family also expressed concerns the resident was not being provided properly bathed and dressed, or toileted in a timely manner. Staff were reminded to ensure that the resident did not have any agency PSW staff assigned to provide care.

The staffing plan failed to ensure that resident #002's care was consistent with the resident's care needs due to short-staffing and use of agency staff.

3. Related to Log # 025721-18:

A critical incident report (CIR) was submitted to the Director on a specified date for an

alleged staff to resident abuse. The CIR indicated on a specified date and time, resident #004 was transferred into bed by RN #102 and a family member. The family later reported RN #102 was abusive during care.

Review of the home's investigation, interviews with staff indicated and review of the staffing schedule indicated on the specified date and shift, when the incident occurred, they were working short- staffed for PSWs.

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 staffing plan (a) provided for a staffing mix that is consistent with the residents assessed care and safety needs, (b) set out the organization and scheduling of staff shifts, (c) promoted continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, (d) included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) and (e) got evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

The licensee has failed to ensure that the resident's SDM and any other person specified by the resident, were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Log #000500-19:

Review of a critical incident report (CIR) was submitted to the Director on a specified date, for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, resident #005 had reported to RPN #103 that resident #004 had allegedly abused the resident. RPN #103 reported the allegation to RN #102. The CIR was completed by former DOC #105.

Review of the progress notes for resident #005 indicated there was no documentation related to the incident.

Review of the progress notes for resident #004 indicated on a specified date and time, RN #102 documented resident #005 reported that resident #004 had abused the resident, could not tell RPN #103 where the resident incident occurred and the incident

was unwitnessed. The following day, RN #102 updated the resident's SDM of the alleged resident to resident abuse incident from the previous day.

Interview with RN #102 by Inspector #111, the RN confirmed they were working when RPN #103 reported an alleged resident to resident abuse. The RN indicated RPN #103 reported that resident #005 informed the RPN that resident #004 had abused the resident. The RN indicated that since the incident was not witnessed, they did not need to report it to anyone. The RN confirmed they did not inform the SDM of resident #005 and reported the incident to the SDM of resident #004 until the following day.

Interview with RPN #103 by Inspector #111, the RPN confirmed they were working when resident #005 reported to them, that resident #004 had abused the resident. The RPN was unable to recall if they documented the incident in each of the resident's health record but confirmed reporting the allegation to RN #102. The RPN confirmed they did not contact the SDM of either resident.

Interview with the ED by Inspector #111, the ED indicated RN #102 received disciplinary action, as a result of the investigation, for failing to immediately report the allegation of resident to resident abuse.

The licensee failed to ensure that both resident #004 and #005's SDMs were notified within 12 hours upon becoming aware of an alleged incident of physical abuse. [s. 97. (1) (b)]

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Log# 025721-18:

Review of a critical incident report (CIR) was submitted to the Director on a specified date, for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, a family member of resident #004 reported RN #102 was abusive while assisting with personal care. The CIR was completed by (former) acting ED #106 and RN #104 (former acting DOC).

Review of the investigation into the allegation of staff to resident abuse involving resident #004, the acting ED (#106) was notified by RN #102 on same day the allegation was

made.The Acting ED no longer works in the home. The investigation was concluded as founded. There was no documented evidence that the SDM of resident #004 was notified of the outcome of the investigation.

During an interview with the Executive Director (ED) by Inspector #111, the ED confirmed they were not working in the home at the time the incident occurred. The ED confirmed the former acting ED (#106) no longer worked in the home. The ED indicated there was an acting DOC also in place (RN #104) when the allegation was reported. The ED confirmed there was no documented evidence the SDM of resident #004 was notified of the outcome of the investigation, despite the allegation as founded.

During an interview with RN #104 (former acting DOC), by Inspector #111, the RN confirmed they had not informed the SDM of resident #004 of the outcome of the investigation as the RN assumed the acting ED would have notified the SDM.

The licensee failed to ensure that the SDM of resident #004 was notified of the results of the alleged abuse investigation immediately upon the completion.

3. Related to Log #000500-19:

Review of a critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, resident #005 had reported to RPN #103 that resident #004 abused the resident. RPN #103 reported the allegation to RN #102.

Review of the investigation into the allegation of resident to resident abuse involving resident #004 and resident #005 indicated:
-There was no documentation in resident #005's health care record regarding the incident, to indicate the resident's SDM was notified of the incident or the outcome of the investigation.
-The investigation was concluded on a specified date, but there was no documented evidence that the SDM of either resident were notified of the outcome of the investigation.
-The acting DOC (#105) no longer works in the home and unable to interview. The current DOC and ED were also involved in the investigation.

Interview with RN #102, the current DOC and the current ED, by Inspector #111, all confirmed no documented evidence that the SDM of resident #004 or #005 were notified

of the outcome of the investigation, upon its completion.

The licensee failed to ensure the SDM of resident #004 and #005 were notified of the results of the alleged abuse investigation immediately upon the completion.

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 and any other person specified by the resident, were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident and that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: a response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Related to Log # 009678-18, Log #009498-18, Log #008122-18 and Log # 025567-18:

There were four anonymous complaints were received by the Director regarding concerns with managing complaints.

During an interview with RPN #121 by Inspector #111, the RPN indicated that any verbal complaints received, they try to resolve where possible but if unable to resolve, then they immediately notify the RN or manager on call. The RPN indicated any written complaints received are immediately forwarded to the manager.

During an interview with RN #104 by Inspector #111, the RN indicated any verbal complaints they cannot resolve immediately, they would complete a client feedback form and forward to the ED. The RN indicated any written complaints received are immediately forwarded to the ED. The RN indicated they recently completed two client feedback forms, one for resident #001 and resident #030.

During an interview with resident #001 by Inspector #111, the resident indicated they had an ongoing concern with medication administration but the concern was eventually resolved. The resident indicated they were upset with how long it took to get their concern resolved.

Review of the progress notes for resident #001 related to concerns with medication indicated:
-on a specified date and time, RN #103 indicated the resident voiced a concern that they were not receiving a specified medication, at a specified time. The RN explained to the resident, that the nurse who administers their medication, had to remain on the unit to supervise the meal on that unit and as the resident went to the lower level for their meals, the resident would have to either return to the unit for the medication or receive the medication before they left the unit.
-Two days later at a specified time, RN #103 indicated the resident was asking again to have a specified medication administered at a specified time.
-Two weeks later, the resident appeared to be upset and informed the PSW of their concern regarding not receiving a specified medication, at a specified time.
-The following day and at a specified time, RN #103 indicated the resident continued to request that the nurse provide their specified medication at a specified time. The RN indicated, it had been clearly explained to the resident that the RPN on the unit could not leave the dining room during the meal to administer the resident's medication as

requested, as the resident went to the main dining room for meals. The resident was reminded that this was already discussed previously, but the resident remained dissatisfied. The resident indicated their medication was not being administered as prescribed, as the medication was to be taken with meals.
-A few days later, at a specified time, the resident was in the main dining room and requested a staff member call the nurse for their specified medication. The staff member was directed by the nurse to have the resident return to their floor after their meal to receive their medication. The resident returned to their floor and informed the nurse that they were supposed to receive the specified medication during the meal. The resident was informed that the nurse in the main dining room does administer medications. The resident reported that other residents were observed to receive their medications in the main dining room and the nurse explained that this is not a routine practise. The resident remained upset.
-Two days later, at a specified time, the resident came to nursing station, was upset because they did not receive their medication during their meal and began to yell at staff. The RRN contacted RN #140 and the acting DOC (#105). The RPN later approached the resident in the resident's room and the resident was heard on the phone stating, "I'm calling CCAC tomorrow and I'm getting out of here". The resident was placed on DOS monitoring for responsive behaviours.
-The following day at a specified time, the resident was notably upset at the start of shift, lying in bed crying. The resident continued to voice their frustration regarding the administration of their medication.
-Three days later, at a specified time, the resident requested the RPN bring their specified medication and was reminded by the RPN that they could not leave unit and the resident could return to unit after the meal to receive their medication.
-The following day at a specified time, the resident was at the nursing asking if the RPN was able to bring the medication to them during their meal and the RPN refused, indicating it was policy not to give medications in the main dining room. The resident was directed to speak to the acting DOC.
-The following day at a specified time, the resident again requested to have the medication given during the meal and was again told by the RPN they were unable to administer medication in the main dining room. The resident indicated they had a doctor's note indicating they were to receive their medication in the dining room and the resident was told to discuss with the DOC or ED. Later the same day, the acting DOC (#105) met with the resident as the resident "has been very concerned" that they were not receiving their specified medication with meals. The DOC indicated the current order was to give the medication 'after eating' and the resident wants the medication during their meal. The DOC indicated this was "difficult to facilitate as the resident's RPN is

monitoring the dining room on their specified floor and the resident eats their meal on the main level". The DOC indicated "legislation does not allow for the RPN to leave the dining room unattended". The DOC indicated the resident received an order from the physician to have the medication in the middle of the meal. The acting DOC #105 called to clarify the order. The acting DOC indicated the plan was to obtain an order from the physician to allow the resident to self-administer the medication to facilitate the resident's preference. The same day, the resident again requested to have their medication administered as prescribed, during their meal. The RN indicated the RPN administering the medications was unable to give the medication in the main dining-room. The RN and RPN indicated the proposed resident self-administering the medication still required an order from the physician, as well as the requirements of the self-administration policy. The resident again agreed with this option and a note was left in the physician binder regarding the resident's request.
-The following day, RN #104 indicated the medication could not be self-administered until policy requirements were met and they were unable to complete due to time constraints. The following shift, the resident was explained the process regarding the self-administering of medications and the resident was required to 'sign the written agreement'. The resident became upset and verbally aggressive. The nurse notified the ED regarding the incident.
-The following day at a specified time, the resident was reminded they had to take their medication on the unit as they had not been authorized to self-administer their medication. The resident remained upset.
-The following day, the RPN attempted to have the resident sign the self-administration agreement and the resident refused. The resident was informed of only two options, come to the unit to take the medication during the meal or sign the self-administration agreement. The RPN also informed the resident they would notify the physician to discontinue the self-administration order if the resident didn't change their mind. The resident agreed to sign the self-administration form. The nurse indicated that there was only a physician order to self-administer with one meal and not all meals, so the physician would be notified to change the order.
-Three days later, the physician indicated they signed an order for the resident to self-administer the specified medication during meals.

The resident had initially voiced concerns regarding receiving their specified medication during meals, on a specified date and their verbal complaints were not resolved until approximately two months later. The ongoing explanations provided to the resident were contradicting, as the resident was also supposed to be supervised by registered staff in the main dining room and other residents were able to receive their medication in the

main dining room. The final resolution (self-administration) was the only alternative provided to the resident to resolve the residents ongoing verbal complaint, and this resolution also took almost another week to implement which further upset the resident. The resident's ongoing verbal complaints related to medications administration did not have any documented client feedback forms completed either, as per the licensee's complaint policy.

During an interview with DOC by Inspector #111, the DOC indicated they had not received any client feedback forms, regarding any verbal complaints. The DOC indicated all client feedback forms usually went directly to the ED.

During an interview with the ED by Inspector #111, the ED indicated they would complete a client feedback form for any verbal complaints not resolved within 24 hours and any written complaints. The ED indicated they could only locate one documented client feedback form (for a verbal complaint) for a different resident.

The licensee failed to ensure that a verbal complaint made to the licensee concerning the care of resident #00, that a response was provided to the resident who made the complaint, indicating what the licensee had done to resolved the complaint. [s. 101. (1) 3.]

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

Review of the licensee's complaints and customer service policy (RC-09-01-04) updated April 2017, indicated under procedures:
-each contact with the complaint should be recorded on the contact log by the person making the contact.
-On page 4 of 7, maintain a record of all complaints and actions taken in the complaint log. See complaint log, Appendix 5. Monitor the resolution of concerns/complaints monthly to identify trends and opportunities for quality improvement.
-On 5 of 7, complete a concern/complaint investigation form in detail if the complaint cannot be resolved within 24 hours, and forward to the Administrator/department

manager. See complaint investigation form, Appendix 1.

Related to Log # 017787-18:

An anonymous complaint was received regarding care not provided as a result of short staffing. The complaint indicated the concerns were brought forward to the home on several occasions but the issue continued.

Review of the progress notes for resident #002:
-on a specified date and time, RN #102 informed the resident in the morning that they would have to remain in bed for breakfast due to being short staffed and not having time to get the resident up for breakfast. The RN indicated a tray would be brought to the resident. When the breakfast tray was brought to the resident, the resident refused breakfast. A few minutes later, it was reported that resident was crying and wanted to get up out of bed.
-Approximately a week later at a specified time, the nurse indicated that "due to staffing shortages, unable to complete resident's routine bath" and notified the acting ED.
-The following day at a specified time, the resident was observed crying and reported that the agency PSW in the morning did provide proper hygiene and as per the resident's preferences. The nurse met with the agency PSW who provided morning care. The PSW apologized and confirmed the residents morning care was not provided, as per resident plan of care. After the nurse reviewed the residents care plan, the nurse noted that it was also the resident's preference, not to have any agency staff provide care.
-On a specified date and time, resident's bath was not completed this shift related to it being too late to complete the bath.
-On a specified date and time, the family called the home to express concerns that the resident was not offered their meal. The RPN indicated the resident was offered but refused. The family member indicated the resident refused their meal because the resident had not been dressed appropriately to attend the dining room. The family requested to speak to RN #104.
-The following day, at a specified time, the family called and expressed concerns related to residents care to RN #104. The family member indicated, when they were in visiting, they noted a strong urine odour, noted the resident had not received continence care and the mobility aide was also saturated. The family member indicated they wanted to ensure staff were toileting/checking the resident routinely. Staff were directed to document every shift on frequency of toileting. The family also expressed concern from the day before when the resident was left in their night clothes until the afternoon and the resident was upset. The staff explained to the family member the delay in bathing was because of

short staffing and staff would be directed to ensure that the resident is appropriately dressed for the day.
-On a specified date and time, the family was in to visit and expressed concerns regarding the resident still having agency PSW's assigned to provide the residents care. The family also expressed concerns the resident was not being properly bathed and dressed, or toileted in a timely manner. Staff were reminded to ensure that the resident did not have any agency PSW staff assigned to provide care.

Review of the written plan of care for resident #002 indicated no agency staff were to be used to provide care and if unable to assist with full am care prior to breakfast, please offer to assist the resident into pyjamas or housecoat for breakfast. For urinary incontinence, check resident every three hours for wetness or need to use the toilet, uses a specified incontinent product and on Prompted Voiding Program (ask and assist resident to go to washroom).

During an interview with the ED by Inspector #111, the ED indicated they had no documented client feedback forms (for ongoing verbal complaints of care not provided as indicated in the plan) for resident #002.

The home had no documented evidence of the ongoing concerns identified by resident #002 or the family, related to care not provided as indicated in the plan.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all complaints, specifically verbal, that cannot be resolved within 24 hours, shall be investigated and resolved where possible and a response provided to the complainant within 10 days and a documented record is kept of all complaints to indicated: (a) the nature of each verbal or written complaint, (b) the date the complaint was received, (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, (d) the final resolution, if any, (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures that were developed, were implemented for addressing incidents of lingering offensive odours.

Related to Log # 017787-18:

An anonymous complaint was received on a specified date indicating their were lingering odours of urine on the third floor.

Observation of the third floor on a specified date and time, indicated no foul odours of urine were noted. Observation of several resident rooms on the third floor indicated a specified shared resident bathroom, had a strong, lingering offensive odour of urine.

During an interview with PSW #132 by Inspector #111, the PSW confirmed that the specified, shared resident bathroom had a lingering odour of urine.

During an interview with HSK #133 by Inspector #111, the HSK indicated that the resident rooms/bathrooms were cleaned daily and confirmed that the specified resident shared bathroom had a lingering urine odour, despite already being cleaned and garbage emptied.

During an interview with the Environmental Manager(EM), the EM indicated no awareness of a lingering urine odour in the specified shared resident bathroom. The EM indicated the bathroom was identified with an odour on the 'odour checklist' back in the spring and indicated the odour appeared to be from the floors (under the tiles) and the flooring would have to be replaced.

The licensee has failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours in resident bathroom 301/302.

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), KARYN WOOD (601), PATRICIA MATA (571)
Inspection No. / No de l'inspection :	2019_643111_0002
Log No. / No de registre :	003325-18, 006357-18, 008122-18, 008678-18, 009199-18, 009678-18, 012875-18, 014307-18, 016487-18, 016749-18, 017787-18, 019121-18, 025567-18, 025571-18, 025573-18, 025721-18, 030661-18, 000500-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 26, 2019
Licensee / Titulaire de permis :	CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Hope Street Terrace 20 Hope Street South, PORT HOPE, ON, L1A-2M8

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 : Colleen Haley

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To CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.20(1).

Specifically, the licensee shall:
1. Ensure that all registered nursing staff and management staff are retrained on the licensee's zero tolerance of abuse and neglect policy to ensure they are aware of requirements regarding assessments of residents who report allegations of abuse, documentation, investigation and reporting requirements.
2. A documented record must be kept of the re-training.

Grounds / Motifs :

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

Review of the licensee's policy Zero Tolerance of Resident Abuse and Neglect (RC-02-01-01, RC-02-01-02 and RC-02-01-03), updated April 2017, indicated in (RC-02-01-02):
-page 2 of 5, the Administrator or designate: immediately initiate an investigation of the alleged, suspected or witnessed abuse.
-page 3 of 5, ensure the safety of, and provide support to the abuse victim, through completion of full assessments, a determination of resident needs and a documented plan to meet those needs.
-page 4 of 5, any employee or person who becomes aware of an alleged, suspected or witnessed resident indicate of abuse or neglect will report it immediately to the Administrator/designate/reporting manager.
(RC-02-01-03): page 1 of 5, all reported incidents of abuse and/or neglect will

objectively, thoroughly and promptly investigated. On page 3 of 5, in cases where the allegation of abuse or neglect is made against an employer, management will: immediately advise the employee that they are being removed from the work schedule, with pay, pending the investigation; during the investigation, the investigating manager/supervisor will: maintain the security and integrity of the physical evidence at the site of incident fully investigate the incident and complete the documentation of all known details in keeping with the steps outlined in the investigation toolkit. See National Workplace Investigation Toolkit-Appendix 2. Under Appendix 2, Step 1: consulting company policies, procedures and standards. Collect employee statements. Prior to the start of your interviews, create a list of all witnesses who have direct or indirect knowledge of the incident.

Related to Log #025721-18:

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged staff to resident abuse incident. The CIR indicated on a specified date and time, a family member of resident #004 reported RN #102 was abusive to the resident. The CIR was completed by the former acting Executive Director (ED) #106 and RN #104, who was the former acting DOC.

Review of the health record for resident #004 and review of the investigation into the allegation of staff to resident abuse for resident #004 indicated:
-On a specified date and time, RN #102 had assisted a family member with a transfer of resident #004 and provided continence care. After care was provided, the family alleged the RN was abusive. Later in the shift, the family reported to the RN again that they had been abusive to the resident. RN #102 apologized and then called the manager (RN #105 who was the former acting ED) to report the allegation.
-RN #105 no longer worked in the home, but the investigation indicated RN #104 (former acting DOC) was also involved in the investigation.
-The day after the allegation was reported, the investigation was initiated after the family were contacted and confirmed the allegation of staff to resident abuse.

-The only staff member interviewed was RN #102. There was no documentation related to the family interview. There were no interviews of any other staff who were working when the incident occurred.

-On a specified date, the investigation was concluded as founded and appropriate actions were taken to prevent a recurrence.

During an interview with the Executive Director (ED) by Inspector #111, the ED indicated that RN #102 received disciplinary action as a result of the allegation of staff to resident abuse involving resident #004 that occurred on a specified date. The ED indicated they were not working when the incident occurred, was covered by acting ED (#106) and the former ED no longer worked in the home. The ED also indicated that acting DOC (#105) was also in place at the time of the incident but no longer works in the home.

During an interview with RN #102 by Inspector #111, the RN indicated on a specified date and time, a family member of resident #004 was requested assistance with a transfer of resident #004 and with continence care. The RN indicated they were busy that shift as they were short staffed and the PSWs were busy in the dining room at the time. The RN indicated they initially told the family they would have to wait until after the meal but then assisted the family member with the resident. The RN indicated the family member then alleged the RN was abusive with the resident. The RN confirmed awareness that the resident was a two staff assistance with all personal care and should not have transferred the resident with a family member. The RN indicated the family member later the same day, again complained that the RN was abusive to the resident. The RN indicated that they apologized to the family, documented the incident in the progress notes and then notified the acting ED (#106) of the incident and the allegation. The RN indicated the ED reminded the RN to always use two staff for transfers and continued to work the remainder of their shift. The RN indicated they came in to work the following day and halfway through their shift, the management informed the RN that they were relieved of duty pending the investigation.

During an interview with RN #104 by Inspector #111, the RN indicated they were acting DOC during the time of the incident, as the DOC was on a medical leave. The RN indicated resident #004 had advanced dementia and requires two staff assistance with transfers and continence care. The RN indicated RN #102 did notify the acting ED #106 the same day of the incident and allegation. The RN confirmed that the investigation was not completed until the following day, when the family was contacted and confirmed the allegation. The RN indicated they

were not directly involved in the investigation. The RN indicated no awareness of any other staff being interviewed regarding the incident when the incident occurred.

The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with as, they failed to ensure there was complete documentation of all known details in keeping with the steps outlined in the investigation toolkit, as an interview with the family was not documented. According to the National Workplace Investigation Toolkit-Appendix 2. Under Appendix 2, Step 1: create a list of all witnesses who have direct or indirect knowledge of the incident and collect employee statements, was not completed as all staff who were working (i.e. the PSW's) were not interviewed or statements obtained, only RN #102 and in cases where the allegation of abuse was made against an employee, management was to immediately advise the employee that they are being removed from the work schedule, and RN #102 continued to work until the following day when the investigation was initiated.

2. Related to Log #000500-19:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident. The CIR indicated on a specified date and time, resident #005 had reported to RPN #103 that resident #004 had been abusive to the resident. RPN #103 reported the allegation to RN #102. The CIR was completed by the former acting DOC (#105).

Review of the investigation into the allegation of resident to resident abuse that occurred by resident #004 towards resident #005 indicated:
-The acting DOC #105 no longer works in the home and unable to interview.
-The investigation did not have any interviews of any residents or any other staff that were working (i.e. RPN#103) and only a written statement was received by RN #102.
-The investigation was concluded on a specified date and actions were taken (related to RN #102) but no indication of an outcome related to the resident to resident alleged abuse incident.

Review of the progress notes for resident #004:

-On a specified date and time, RN #102 indicated resident #005 reported to RPN #103 that resident #004 had abused the resident, could not indicate where the incident occurred and indicated the incident was un-witnessed.
-the following day, RN #102 indicated they contacted the SDM about the alleged incident and the SDM was updated on the incident from yesterday. RN #104 indicated, monitoring of resident due to allegation of abuse by co-resident #005 yesterday. Every 15 minute monitoring initiated.

Review of the progress notes for resident #005 indicated there was no documentation on the specified date related to the incident.

During an interview with RN #102 by Inspector #111, the RN confirmed on a specified date and shift, that resident #005 informed RPN #103, that resident #004 had been abusive towards them, and then the RPN reported the incident to the RN. The RN indicated that since the incident was not witnessed, the incident did not need to be reported to anyone. The RN confirmed they did not assess resident #005 or investigate the incident to determine details surrounding the incident. The RN indicated the following day, they reported the incident to the acting DOC at morning report and after the RN completed working their shift, they received a call regarding the allegation and was informed at that time that they were off work pending the investigation.

Interview with RPN #103 by Inspector #111, the RPN indicated on a specified date and time, there were at the nursing station where resident #004 was also present. The RPN indicated a PSW then reported that resident #005 reported to them, that resident #004 had been abusive to the resident. The RPN was unable to recall which PSW reported the allegation. The RPN indicated they asked resident #005 where they were struck but the resident was unable to recall. The RPN confirmed they did not document the alleged incident in either resident's health record but reported the allegation to RN #102. The RPN indicated they were asked about the incident the following day, by the former acting DOC (#105).

The licensee failed to ensure the policy that promotes zero tolerance of abuse and neglect was complied with as, there was no documentation in resident #005's health care record regarding the incident and no indication the resident was assessed. All staff who were present or aware of the incident (PSW and

RPN) were not interviewed and/or statements obtained. RN #102 was made aware of an alleged resident to resident abuse, by resident #004 towards resident #005 and did not immediately report it to the Administrator, designate or reporting manager or assess the resident.

The scope was a level 2, as two out of three residents that were reviewed did not have the policy complied with. The severity was a level 2, potential for harm, risk of harm as the residents and or SDM's had alleged abuse in both incidents. The compliance history was a level 4, ongoing non-compliance with LTCHA, 2007, s.20(1) as follows:
-on April 21, 2016 during an RQI, the home was issued a Voluntary Plan of Correction (VPC) during inspection #2016_293554_0004
-on September 27, 2016 during a critical incident inspection, the home was issued a VPC during inspection #2016_195166_0026.
-on October 3, 2017 during a critical incident inspection, the home was issued a VPC during inspection #2017_673554_0021. (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.24(1).

Specifically,
1.The licensee shall ensure that a person who has reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, or 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, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.
2.The licensee shall create a documented process, to ensure that the Director has been notified immediately, whenever a person suspects improper or incompetent treatment or care of a resident; or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Grounds / Motifs :

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

licensee or staff that resulted in harm or risk of harm.

Related to Log #025721-18:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident abuse incident that occurred the day before at a specified time. The CIR indicated the family of resident #004 alleged RN #102 was abusive to resident #004. The CIR was completed by the former acting Executive Director (ED) #106 and former action DOC (RN #104).

Related to Log #000500-19:

A second critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident that occurred the day before at a specified time. The CIR indicated resident #005 alleged resident #004 was abusive to the resident and reported the allegation to RPN #103 who reported the allegation to RN #102. The CIR was completed by the former acting DOC #105.

Review of the progress notes for resident #004 indicated:
-On a specified date and time, RN #102 documented that the resident's family member wanted the resident transferred back into bed, provided continence care and repositioned in bed. The RN explained to the family that the resident required two staff assistance and that transferring the resident back to bed would have to wait until the meal was over as the other staff were in the dining room assisting with the meal. The RN indicated they ended up transferring the resident into bed with family member assistance but during the transfer, the resident was asleep/very difficult to move and the family member was unable to assist with the lift. The resident was incontinent and was also changed. The RN indicated the resident would require two staff to reposition in bed and would be assisted by staff when the lunch meal was over. The family member then indicated they thought the RN was " too rough". The family member then left the home. Later the same day, the RN had to call the family member to report a different issue and the family member again alleged the RN was too rough with the resident. The RN apologized to the family member and notified the acting ED #106 of the allegation. There was no indication the Director was notified.
-On a specified date and time, RN #102 documented that resident #005 reported

to RPN #103, that resident #004 had punched the resident and the incident was unwitnessed. There was no indication the Director was notified.

During an interview with RN #102 by Inspector #111, the RN indicated on a specified date, they were busy that day because they were short staffed and the PSWs were busy in the dining room with the meal. The RN indicated they initially told the family they would have to wait until after the meal for staff assistance, but the family insisted, so both the RN and the family member attempted to transfer the resident back to bed. The RN indicated after the transfer and continence care provided to the resident, the family member accused the RN of 'being too rough' with the resident. The RN confirmed awareness that the resident was a two person assist with all personal care and should not have transferred the resident without another staff member. The RN indicated they reported the allegation to the acting ED (#106) later the same day. The RN confirmed they did not report the allegation to the Ministry of Health (MOH) because they assumed the acting ED would have reported the incident. The RN indicated the alleged resident to resident abuse incident involving resident #004 and #005 that occurred on a specified date, was initially reported to RPN #103, who reported the incident to the RN. The RN confirmed that they did not report the alleged resident to resident abuse incident to the Ministry of Health (MOH) because the incident was not witnessed.

During an interview with the current DOC by Inspector #111, the DOC confirmed they started working in the position the day after the alleged resident to resident abuse incident, involving resident #004 and #005 occurred. The DOC indicated they were present during the investigation that included the current ED, the investigation occurred the same day they started, but they were just as 'an observer'.

During an interview with RN #104 (former acting DOC) by Inspector #111, the RN indicated they were acting DOC when a previous incident occurred on another specified date. The RN indicated they also had an acting ED (#106) at the time, but no longer works in the home. The RN indicated RN #102 had assisted the family member of resident #004 with the transfer of the resident, provided continence care to the resident and the family member then expressed concern with how the resident was treated. The RN confirmed the acting ED (#106) was notified at the time of the incident and allegation. The RN confirmed

the MOH was not informed of the allegation until the day after, when the acting ED reported the incident.

During an interview with the Executive Director (ED) by Inspector #111, the ED confirmed both incidents were not immediately reported to the Director, until the day after the allegations were made.

The licensee failed to ensure an alleged staff to resident abuse incident that occurred on a specified date and a second alleged resident to resident physical abuse incident that occurred on a specified date, was immediately reported to the Director as they were both reported the day after the allegations were made.

The scope was a level 2, a pattern as two out of three incident reviewed were late reported. The severity was a level 2, potential for harm as both incidents were reported the day after the allegations were received. The compliance history was a level 4, ongoing non-compliance with LTCHA, 2007, s.24(1) as follows:
-on April 21, 2016 during an RQI, the home was issued a Voluntary Plan of Correction (VPC) during inspection #2016_293554_0004.
-on September 27, 2016 during a critical incident inspection, the home was issued a VPC during inspection #2016_195166_0026.
-on October 3, 2017 during a critical incident inspection, the home was issued a VPC during inspection #2017_673554_0020.
-on October 3, 2017 during a critical incident inspection, the home was issued a VPC during inspection #2017_673554_0021. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 26th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office