Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2017	2017_632502_0012	017057-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (no.1) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

CRAIGLEE NURSING HOME
102 CRAIGLEE DRIVE SCARBOROUGH ON M1N 2M7

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

JULIENNE NGONLOGA (502), BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 2-4, 8-11, 14-18, 21 -25, 28- 30, and September 8, 2017.

The following critical incident report intakes were concurrently inspected with the resident quality inspection: #017807-16, #004103-17, related to staff to resident abuse; #001831-17, #010509-16, #005014-17, #014655-17, related to resident to resident abuse and responsive behaviours; #010766-15, related to responsive behaviours; and #029411-16 related to fall.

The following complaint intakes were inspected concurrently with the resident quality inspection: #020275-16 related to infection control and prevention; #022750-16, related to safe and secure home, nutrition and dehydration, continence care, and personal support services; #031988-16, #032495-16, #034779-16, #005784-17, 013770-17 related to abuse, report and complaints; and #008949-17 related to Resident's Bill of right.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument Coordinator (RAI), Physician, Nurse Managers (NMs), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Nutrition Manager (NM), Registered Dietitian (RD), Dietary Aides (DA), Cooks, Programs Manager (PM), Physiotherapist, Environmental Service Manager (ESM), Maintenance Supervisor, Housekeeping Aide, Social Worker (SW), Clerk-Procurement, Clerk Scheduling, Office Manager, Consulting Pharmacist, Toronto Police Services Detective, residents, Substitute Decision Makers (SDMs) and family members of residents.

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

The following Inspection Protocols were used during this inspection:

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

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

21 WN(s)
8 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, a critical incident report system was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of alleged staff to resident abuse. Review of the CIS and the home's investigation notes revealed that on an identified date, resident #045 was exhibiting specified responsive behaviours during mealtime. When staff #100 entered the dining room to assess the resident, he/she witnessed staff #111 abuse resident #045 resulting in pain.

In an interview, staff #111 stated that he/she had asked resident #045 to stop exhibiting the specified responsive behaviour, but denied abusing resident #045.

In an interview, staff #100 confirmed that he/she had witnessed staff #111 acting inappropriately toward resident #045 the above mentioned incident.

In an interview, staff #129 stated that the home did not find evidence to support the alleged abuse as staff #100 later retracted his/her statement. This contradicted staff #100's statement that he/she had never retracted his/her statement.

In an interview, staff #113 acknowledged that resident #045 was not protected from abuse by staff #111. [s. 19. (1)] (673)

2. On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date and time, resident #037 approached resident #038 and grabbed him/her resulting in an injury to resident #038.

In an interview, resident #038 stated that a few weeks ago, resident #037 exhibited a specified behaviour toward him/her which resulted in an injury. Resident #038 told the inspector that this behaviour was constant, as both residents had been sharing the same room for the past three months.

Review of resident #037's plan of care revealed that resident #037 exhibited specified responsive behaviours towards other residents, and that staff were directed to move resident #037 to a more appropriate environment.

In an interview, staff #128 stated that on the date and time of the above identified incident, he/she observed resident #037 approach resident #038 and an altercation occurred, and both residents were redirected by staff #128. A few minutes later, resident

#037 approached resident #038 and abused him/her resulting in an injury to resident #038. Staff #128 stated that if he/she had known that resident #037 would continue to exhibit the behaviour, he/she would have monitored resident #038 more closely to prevent further incident.

In an interview, staff #129 stated that he/she was aware of resident #037's responsive behaviour toward other residents, since the change in his/her medical condition. Staff #129, further stated that the specific interventions had been implemented.

In an interview, staff #113 acknowledged that abuse occurred, as staff did not ensure resident #038 was safely redirected away from resident #037 after the first incident. [s. 19. (1)] (502)

3. On an identified date a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #011 told staff #165 and an BSO nurse that he/she had voiced a specified threat toward resident #035. Resident #011 was re-approached and repeated this threat.

a) In an interview, resident #035 stated that he/she was involved in an altercation with resident #011 a few months ago, and that he/she was aware that resident #011 had made a specified threat toward him/her, but was not afraid of resident #011 as he/she can defend him/herself. Resident #035 further stated that he/she blames the management of the home, as they did not take the above incident seriously.

Review of resident #011’s annual and quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) revealed that resident #011 had mild cognitive impairment, and exhibited specified responsive behaviours.

Review of resident #011’s progress notes revealed that he/she had exhibited the above mentioned responsive behaviours on multiple occasions.

Record review and interviews with staff #166, #128 and #148 revealed that resident #011 was not closely monitored for two days within a specified period of time after the incident occurred.

b) In an interview, resident #011 stated that he/she was involved in a specified incident with resident #035 and that he/she had made specified threat toward resident #035.

On an identified date, staff #129 stated that specified interventions would be implemented to address resident #011’s identified responsive behaviours.

Observation and interview with staff #133 revealed that the interventions identified by staff #129 were not implemented.

In interviews, staff #148 and #113 acknowledged that resident #035 was not protected from abuse by resident #011 as the above identified by staff 129 interventions were not implemented.

The severity of this incident is actual harm/risk as the resident sustained an injury. The scope of this incident is isolated as three residents were involved. The previous compliance history revealed ongoing noncompliance with VPC. As a result of this non-compliance with LTCHA 79/10, s. 19, a compliance order is warranted. [s. 19. (1)] (502)

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #015 was triggered from stage one for signs of dehydration.

As per O. Reg. 79/10, r. 68 (2)(d), every licensee of a long-term care home shall ensure that the programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Review of the home’s Food and Fluid Intake Monitoring Policy #RC-18-01-01 dated February 2017, revealed that if after considering additional fluid intake, the resident still has not met his/her individual fluid target for three consecutive days, the registered nursing staff must complete a Nursing Hydration Assessment.

Review of resident #015's most recent written plan of care under the focus of Dehydration and Fluid maintenance revealed that resident #015 had an ongoing fair fluid intake with a specified daily fluid requirement.

Review of resident #015's fluid intake for an identified period of time, revealed that on multiple occasions, resident #015's daily fluid intake was less than his/her daily fluid requirement for three consecutive days.

Review of resident #015's progress notes revealed that on an identified date the registered nursing staff had documented to increase resident #015's fluid intake. Three days after, the home’s dietitian assessed resident #015 following a significant weight change for an identified period of time, and documented that resident #015 had poor to fair fluid intake and recommended a nutritional supplement. Thirteen days after, registered nursing staff documented that resident #015 looked weak and lethargic, on the next day, resident #015's fluid intake was less than his/her daily fluid requirement, and then he/she was line listed with a specified health condition. Resident #015 was assessed and signs and symptoms of the above specified health condition were identified.

On the same day, resident #015's primary physician was notified and he/she ordered a specified treatment for two days.

In an interview, staff #101 stated that he/she had not received a referral from the registered nursing staff related to the specified medical condition until after the above treatment was initiated.

In an interview, staff #112 stated he/she was aware that resident #015’s fluid intake was less than his/her daily requirement for three consecutive days on multiple occasions.

Staff #112 told the inspector that he/she had not completed the specified assessment for resident #015, and had not referred the resident to the registered dietitian or the physician as per home's protocol until a specified date, which was 44 days later.

In an interview, staff #113 acknowledged that the registered staff should have completed the specified assessment when resident #015's daily fluid intake was less than his/her daily requirement for three consecutive days; therefore, the home's Food and Fluid Intake Monitoring Policy was not complied with.

The severity of this incident is actual harm/risk as the resident became dehydrated. The scope of this incident is isolated to one resident. The previous compliance history revealed ongoing noncompliance with VPC. As a result of this non-compliance with O. Reg. 79/10, r. 8, a compliance order is warranted. [s. 8. (1) (a),s. 8. (1) (b)] (502)

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours.

On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #038 reported to staff #165 and an identified Behaviour Support Outreach (BSO) nurse that resident #011 had voiced a specified threat toward him/her. On the same day, resident #038 told specialized service members that he/she did not want to be in the same room with resident #011, as result the home implemented specified interventions.

Record review revealed that the intervention specified above was recommended to be initiated immediately until re-assessment of resident #011.

On identified dates during mealtimes, observation of resident #011 revealed that one of the above intervention was not implemented.

In interviews, staff #167 and #168 stated that they only implement the above identified intervention when resident #011 exhibit identified responsive behaviours. In an interview, staff #143 told the inspector that staff are directed to implement the intervention recommended by the specialized team.

2. Record review revealed that the resident #011 had been identified as exhibiting specified responsive behaviour, and identified intervention were to be implemented until re-evaluation.

Record review on the home’s electronic documentation system PCC revealed that on multiple occasions the interventions were not implemented while resident #038 had continued to share the same room with resident #011.

In interviews, staff #142 and #129 stated that the above identified interventions were in place for an identified period of time, which was 11 days prior to when resident #038 was provided with an alternate accommodation away from resident #011. Staff #129 further stated that all interventions should have remained in place until the specialized team reassesses resident #011.

3. In an interview five months after the first incident, resident #011 voiced identified responsive behaviours toward resident #035 and provide details of the specified threats he/she voiced five months earlier. Staff #129, who was present during the above interview, told the inspector that identified interventions would be implemented immediately.

On multiple occasions during the inspection, the inspector observed that the above identified interventions were not implemented for resident #011.

In interview, staff #148 and #133 confirmed that the above identified interventions were not implemented for resident #011 as they were not aware of the recommendations made by staff #129. Staff #133 further stated that resident #011 and #035 should not be left together unsupervised.

Staff #123 had not provided documentation to support that the above identified interventions had been re-evaluated prior to being discontinued. Therefore, the home failed to demonstrate that the interventions developed, after resident #011’s specific threat toward resident #035, and after the safety concerns for resident #038 voiced by specialized service members, had not been implemented to assist residents #038 and #035 who are at risk of harm.

The severity of this incident is actual harm/risk as both residents were harmed as a result of resident #011's identified responsive behaviours and the home's failure to implement the required interventions. The scope of this incident is isolated, and the previous compliance history revealed previous non-compliance unrelated. As a result of this non-compliance with O. Reg. 79/10, r. 55, a compliance order is warranted. [s. 55. (a)] (502)

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

On an identified date a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #011 told staff #165 and an identified BSO nurse that he/she had voiced a specified threat toward resident #035. Resident #011 was re-approached and repeated this threat.

Record review of a BSO team and interview with staff #129 revealed resident’s #011 responsive behaviours triggers.

In interviews, staff #109 and #148 stated that resident #011's responsive behaviours are unpredictable and therefore were not able to identify his/her triggers.
In an interview, staff #113 acknowledged that the above triggers should have been identified in resident #011's written plan of care. [s. 6. (1) (a)] (673)

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #007 was triggered from stage one for bruises/tears/burns as the inspector observed impair skin integrity on resident #007 on an identified date.

Record review of resident #007’s electronic and paper chart for an identified period of time, failed to reveal that a skin assessment was completed related to the altered skin integrity identified above.

Review of the home’s Wound Care Management, policy number RC-06-12-02, dated July 2016, revealed that care staff are to promptly report changes in skin integrity observed during daily care and weekly bath/shower to the nurse for immediate assessment. Further review of the policy revealed that the nurse is to document all skin breakdown in the interdisciplinary progress notes (or wound progress note) and in surveillance tools, and initiate a Wound Assessment Form for each open area, wound and keep in the treatment binder.

In an interview, staff #151 stated that he/she was aware of resident #007’s altered skin integrity identified above and he/she did not report this to the registered staff.

In interviews, staff #103, #153, and #154 stated that they were not aware of resident

#007's altered skin integrity identified above. Staff #103 stated that personal support services workers are to inform the registered staff if there is an new altered skin integrity, and the registered staff are to complete a skin assessment, and document it in the skin and wound assessment on the home electronic documentation system PCC.

In an interview, staff #113 acknowledged that staff #151 had not collaborated with each other, as staff #151 failed to inform the registered staff about resident #007's altered skin integrity identified above. [s. 6. (4) (a)] (673)

3. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of CIS submitted to the MOHLTC and the home investigation notes revealed that the home failed to notify resident #046's family in a timely manner of changes in resident #046's medical condition.

Record review of progress notes revealed that on an identified date resident #046 had changes in his/her medical condition. A specified treatment was administered, and that resident #046 was transferred to the hospital, and then discharged three days later with a specified diagnosis.

In interviews, staff #138, #147 stated that resident #046 was administered a specified treatment for a period of time prior to him/her being transferred to the hospital. Staff #147 further stated that he/she had initiated the treatment, had not informed the family, as he/she endorsed that to staff #112 and #150 to inform the family of the change in the resident medical condition.

In an interview, staff #112 stated that he/she had not informed the family as he/she was not informed about the resident #047's change condition and the administration of the treatment identified above.

In an interview, Staff #113 stated that the home's process after administrating a treatment is to inform the resident's SDM. Staff #113 acknowledged that staff #147 and #150 should have informed resident #047's family about the administration of treatment identified above, in order to give them an opportunity to participate in the implementation of resident #047's plan of care. [s. 6. (5)] (673)

4. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #038 reported to staff #165 and an identified specialized staff that resident #011 had voiced a specified threat toward. On the same day, resident #038 told specialized staff members that he/she did not want to be in the same room with resident #011, as result the home implemented specified interventions.

Record review on the home's electronic documentation system PCC for an identified period of time revealed that on multiple occasions the interventions identified above were not implemented for resident #011.

In interviews, staff #129 and #113 stated that the interventions identified above for resident #011 were implemented, but had not provided documentation for during the period identified above. [s. 6. (9) 1.] (502)

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #003 was triggered from the most recent MDS for incontinence.

Review of the RAI-MDS most recent quarterly assessment, revealed that resident #003 was frequently incontinent. Further review of the RAI-MDS assessment revealed that resident #003's continence level had declined from the previous RAI-MDS assessment three months prior, where the resident was identified as being usually continent.

Review of the home's Continence Management Program policy #RC-14-01-01, revised in February 2017, revealed that staff would complete a continence assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence, with any deterioration in continence level.

Review of resident #003's continence assessment record on the home electronic record PCC revealed the most recent continence assessment was completed two and half months before resident #003's continence level declined.

In an interview, staff #103 confirmed that resident #003's continence assessment had not been completed, and was aware that the resident should have been re-assessed when the continence level changed.

In an interview staff #113 , stated that the home’s policy directs nursing staff to complete a continence assessment of the resident when his/her continence level changed and acknowledged that resident #003 should have been assessed and referred to the continence care team. [s. 6. (10) (b)] (502)

6. Review of a complaint was submitted to the MOHLTC on an identified date, revealed that the home did not have enough staff on the floor to toilet residents, and as a result, the residents were forced and told by the personal support workers to go in their incontinent care products.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly assessment, revealed that resident #036 was incontinent. Further review of the RAI-MDS assessment revealed resident #036’s continence level had changed from the previous RAI-MDS assessment three months prior, where the resident was identified as being frequently incontinent.

Review of resident #036’s continence assessment record on the home electronic record PCC revealed the most recent continence assessment was completed 27 months before resident #036’s continence level declined.

In an interview, staff #103 confirmed that resident #036's continence assessment was not completed after the continence level had changed.

In an interview, staff #113 acknowledged that resident #036 should have been assessed and referred to the continence care team when the continence level changed from incontinent to usually incontinent. [s. 6. (10) (b)] (502)

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 a written plan of care for each resident that sets out the planned care for the resident,
- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care,
- the provision of the care set out in the plan of care is documented, and
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, its furnishings and equipment were maintained in a safe condition and in a good state of repair.

On an identified date, the MOHLTC received a complaint related to food quality. The

complainant stated that a resident was given sandwiches for lunch that were often stale and had mold spots on the bread.

On identified date, the inspector observed the refrigerator’s racks covered with rust and the exhaust tube inside the refrigerator covered with calcareous coating, which was crumbling onto the food items stored in the refrigerator.

In an interview, staff # 143 stated that he/she was aware of the rusted racks in the cooks’ refrigerator and that it is an old piece of equipment. He/she later communicated the concern with the Maintenance Supervisor. Staff #157 told the inspector that the refrigerator was put out of service following the inspector's inquiry. This was confirmed by staff #140. [s. 15. (2) (c)] (502)

2. On identified date, resident #035 stated that a shower chair in the second floor shower room was cracked and part of the seat was missing, posing a high risk of altered skin integrity. Resident #035 further stated that he/she had made a complaint to the staff #140 six months prior to this inspection as no action was taken by any staff to address his/her concern. The resident stated that although staff #140 had told him/her that a new chair would be purchased at the time of the complaint, there was no follow through on this action to date.

On the same date in the second floor West shower room, the inspector observed a cracked shower chair with a sharp edge on the seat. Staff #110 told the inspector he/she was aware that the chair was not safe for the resident, but there was no other chair to use when showering the residents. Staff #110 further stated that all staff were aware of the issue and that resident #038 had complained to the staff #140.

In an interview, staff #140 stated that he/she was aware of the unsafe chair and a replacement chair was ordered six months prior to this inspection, but was unaware that the chair had not been replaced yet.

In an interview, staff #134 stated that the home's process is for nursing staff to report any unsafe equipment including shower chairs to the maintenance department, who would then send him/her a purchase order. Staff #134 further stated that he/she was unaware that the third floor’s shower chair was unsafe as the home had four new chairs stored in the Pandemic Room. [s. 15. (2) (c)] (502)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, its furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #006 was triggered from stage one for impair skin integrity as the inspector observed altered skin integrity on resident #006 on an identified date.

Review of the home's Wound Care Management policy, RC-06-12-02, dated July 2016, revealed that a resident exhibiting any form of altered skin integrity will receive a skin assessment by a nurse using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. The policy further stated that the nurse is to document all skin breakdown in the interdisciplinary progress notes (or wound progress note) and in surveillance tools, and initiate one Bates Jensen Wound Assessment Form for each open area/wound.

Record review revealed that resident #006 had multiple identified areas of altered skin integrity for the past 12 months and had been referred to specialized services on multiple occasions. Further record review of the home's electronic documentation record PCC for an identified period of time failed to reveal any completed skin assessments by a member of the registered nursing staff.

In interviews, staff #158 and #159 stated that resident #006 has had ongoing altered skin integrity. PSW #158 further stated that he/she had reported the altered skin integrity identified above to staff #116 on an identified date.

In an interview, staff #116 stated that the home's process if a resident is exhibiting altered skin integrity was for the registered nursing staff to complete an impaired skin integrity assessment and follow up with weekly skin assessments. Staff #116 stated that when he/she received report from staff #158 related to resident #006's altered skin integrity identified above, he/she administered a specified treatment, but did not complete a skin assessment as per the home's process.

In an interview, staff #114 stated that he/she was aware that resident #006's altered skin integrity, but he/she had not completed the skin assessment for the above identified altered skin integrity.

In an interview, staff #160 acknowledged that a skin assessment should have been completed by staff #114 for resident #006's altered skin integrity identified above

In interviews, staff #126 and #113 stated that the registered nursing staff are expected to complete and document skin assessments for residents with impaired skin integrity, and weekly skin assessments thereafter. DOC #113 acknowledged RPN #114 and #116 should have completed skin assessments for the identified weeks for resident #006. [s. 50. (2) (b) (i)] (673)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions are taken to meet the needs of the resident with responsive behaviours included reassessments.

Resident #010 triggered in stage one for increased resistive care.

Review of the RAI-MDS assessment and look back report for an identified period of time, revealed resident #010 had refused to take specified medications.

Review of the home's Responsive Behaviour policy #09-05-01 dated September 2010, revealed on page one, that resident behaviour assessment tools within the home include:

- MDS 2.0 and the Aggressive Behaviour Scale (ABS),
- Dementia Observation Scale (DOS), and
- Cohen/Mansfield Agitation Inventory (CMAI).

Review of resident #010's written plan of care completed on an identified date, revealed that resident #010 exhibits identified behaviours and interventions to address resident #010 behaviour were listed.

Attempts to interview resident #010 were unsuccessful as he/she would turn his/her head away when approached by the inspector. Review of resident #010's RAI-MDs quarterly assessment for an identified date revealed resident #010 was moderately impaired, had a poor decision-making capability, and that he/she requires cues or supervision.

Review of electronic medication administration records (e-MAR) revealed that resident #010 had exhibited the responsive behaviours identified above daily for a period of three months.

In an interview, staff #123 stated that resident #010 routinely exhibited the responsive behaviours identified above even though the above mentioned interventions have been utilized. Staff #123 further stated he/she was not aware that exhibited the behaviours identified above was a responsive behaviour that needed to be reported, and stated that he/she had not implemented the interventions, and could not recall if a referral to the home's internal behavioural support team had been completed.

In an interview, Staff #129 stated that referrals to the social worker should be completed with any new behaviour or ongoing behaviour. Staff #129 stated he/she had not received a referral for resident #010's related to responsive behaviours identified above, until after the inspector had completed an interview that same day with this Staff. Staff #129 acknowledged the home had failed to include reassessments to meet the needs of resident #010. [s. 53. (4) (c)] (589)

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 behavioural triggers have been identified for the resident demonstrating responsive behaviours and actions taken to meet the needs of the resident with responsive behaviours including reassessments., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

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

On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date and time, resident #037 approached resident #038 and grabbed him/her resulting in an injury to resident #038.

Review of resident #037's progress notes revealed that he/she had exhibited identified responsive behaviours on multiple occasions toward co-resident including resident #037.

In interviews, Staff #122, #164, #148, and #129 stated that resident #037's responsive behaviour identified above had worsened with his/her specified diagnosis. The staff further stated that they advised other residents including resident #038 to avoid resident #037, but they did not identify specific interventions.

In an interview, Staff #113 acknowledged that interventions had not been identified to address the risk of altercation between resident #037 and #038. [s. 54. (b)] (502)

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m.

During the resident quality inspection (RQI) the mandatory dining room observation's inspection protocol was completed and the Resident's Council chair and vice-chair were interviewed.

During the interview, the Residents' Council chair and vice-chair stated that the meal times posted all over the home indicated that the breakfast begin at 0830 hours, lunch at 1230 hours, and dinner at 1700 hours, but staff were never on time and the food was always late. The residents further stated that one time, breakfast had been served at 0855 hours.

On multiple occasions during the inspection, the inspectors observed that breakfast service was not available at 0830 hours on the second and third floor. On an identified date, the, the inspector observed the food cart arrived on the third floor dining room at 0840 hours,

Review of the Resident's Council and Food Committee meeting minutes dated September 6, 2016, revealed that the residents had complained about breakfast often being served late.

In an interview, Staff #167 stated that breakfast often started late when staff were behind in providing morning care to residents and on other occasions, the dietary aides were not on time to start the breakfast service.

In interviews, Staff #143, stated that breakfast has been late quite frequently, and that dietary staff have reported to him/her that there was no nursing staff to start the breakfast service.

In an interview, Staff #113 acknowledged that full breakfast should be served up to at least 0830 hours. [s. 71. (6)] (502)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m, to be implemented voluntarily.

WN #10: 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 :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

Resident #008 triggered from stage one for room odour.

On multiple occasions during stage one, the inspector noted a lingering, offensive odour in resident #008's room.Further observation during the above dates and times revealed an air freshener on the floor behind resident #008's commode and broken caulking around the base of the toilet.

On an identified date, resident #047 told the inspector that there was a lingering offensive odour in the washroom, which does not resolve even after housekeeping staff clean the washroom. Resident #047 stated that the odour bothered him/her, as the washroom was located directly across from his/her bed.

In an interview, staff #155 stated that the residents' rooms are cleaned three times a day, and the home's process in addressing odours is to sanitize, mop, clean the area, and spray a deodorizer. Staff #155 also confirmed the presence of a lingering odour in resident #008's room, and stated that the urine seems to have seeped through the tiles.

In an interview, staff #156 stated that the washroom in resident #008's room always smells; however, he/she had not brought it up to the Environmental Services Manager.

In an interview, staff #106 stated he/she was not aware that the washroom in resident #008's room had a lingering odour; however, he/she was aware that the toilet seal required caulking as the seal was broken.

In an interview, staff #157 stated that if the caulking under the toilet, a strip used for sealing the toilet, is broken, water, odour, gases, or urine can leak in, and in this case, the floor would have to be cleaned or replaced. Staff #157 stated that the toilet was recently caulked after the issue was brought to the attention of the home by the inspector, and maintenance would follow up with the issue if the caulking did not resolve the issue.

In an interview, Staff #113 acknowledged that the home's procedure was not implemented in addressing the incident of the lingering offensive odor in resident #008's washroom as the odour persisted even after daily cleaning. [s. 87. (2) (d)] (673)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

During the resident quality inspection the mandatory medication inspection protocol was completed. As part of this inspection, medication incidents and errors were reviewed.

A review of the home's medication incident/errors binder revealed two medication incidents had occurred in the past six months prior to the inspection.

On an identified date, resident #028 was admitted to the home from an identified hospital with various underlying health conditions.

1. A review of resident #028s medication record from the hospital revealed an order for a specified medication to be administered orally for 21 days. A review of the resident #028s medication reconciliation form completed a day after the admission to the home and e-MAR revealed the above mentioned medication had been transcribed to be given daily with no end date identified. A review of the e-MAR revealed the medication had been initiated on the same day and was administered for a total of 34 days. Resident #028 received an additional 13 doses of this medication.

In an interview, Staff #125 stated he/she had completed the medication reconciliation form and had neglected to document that the medication was to be given for 21 days only. Staff #125 further stated it is the home's practice that a medication reconciliation form be reviewed by the next two incoming registered staff for accuracy and to ensure that medication is given in accordance with the directions for use by the prescriber.

In an interview, Staff #128 stated he/she had conducted the first review of the medication reconciliation form for resident #028 but had neglected to document that the above mentioned medication was only to be given for 21 days in accordance with the directions for use specified by the prescriber.

In an interview, Staff #113 acknowledged that staff had failed to ensure medication had been administered to resident #028 in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (589)

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act.

On an identified date, a complaint was submitted to the MOHLTC related to improper disposal of personal health information (PHI). Review of the complaint revealed that a neighbour who lives near the long term care home (LTCH) had found in the street a medical waste bag with a resident's last name on it.

Review of resident #030's health record revealed that he/she had been on a specified treatment daily for an identified period of time. Resident #030 no longer resides in the home and therefore observations of resident #002 were conducted.

On an identified date, observations by the inspector revealed resident #002 had a specified treatment for an identified period of time for 16 hours daily. Observations revealed the resident's name, room number, and the specified treatment were written on the package with a black marker.

In an interview, staff #116 stated that empty the above mentioned package are placed in a small clear garbage bag and discarded in the garbage bin located in the dirty utility room. Staff #116 further stated any resident's PHI was to be erased using a black marker, and the housekeeping aide was to remove any garbage located in the dirty utility room daily.

In an interview, staff #137 stated every morning he/she empties the garbage bins located in the dirty utility rooms into the main garbage receptacles. The main garbage receptacles are located along the outside wall that leads to the underground parking. Staff #137 further stated he/she has observed empty package of the treatment mentioned above with resident names identified with a black marker placed in small clear plastic bags and disposed of in the garbage receptacles located in the dirty utility rooms.

In an interview, staff #113 acknowledged that resident 030's personal health information had not been kept confidential in accordance with the Act. [s. 3. (1) 11. iv.] (589)

WN #13: 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. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of section 8 (3) of the Act.

This Inspection Protocol was initiated by the inspector during the RQI, as Director of Care worked in the capacity of a registered nurse from 2300 to 0700 on August 27, 2017, for the purposes of section 8 (3) of the Act.

Review of the home's absent call-in sheets from January to August 2017, and interview scheduling clerk #142 revealed several registered nurse (RN)'s shifts needed to be replaced and staff #113 had assumed the roles of RN on those dates as follows:
- January 15, 2017 - 0700 to 1500 hours,
- May 3, 2017 - 0700 to 1500 hours,
- July 18, 2017 - 2300 to 0700 hours,
- August 8, 2017 - 1500 to 2300 hours,
- August 26, 2017 - 0700 to 1500 hours, and
- August 26, 2017 - 2300 to 0700 hours.

In an interview, staff#113 stated that on multiple occasions over the past eight months, he/she had assumed the roles of RN-Nurse Manager in the home and subsequently did not work in the DOC role on January 16, July 19, August 9, and August 27, 2017. DOC #113 confirmed that during the hours that a Director of Nursing and Personal Care worked in that capacity, he/she had been considered to be the registered nurse on duty and present in the long-term care home for the purposes of section 8 (3) of the Act. [s. 8. (4)] (502)

WN #14: 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 :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported is immediately investigated.

On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #038 reported to staff #165 and an identified specialized staff that resident #011 had voiced a specified threat toward him/her.

The home's investigation notes were not available to review. Staff #129 told the inspector that staff #165 was in charge of conducting the investigation, as the incident was reported to him/her.

In an interview, Staff #165 provided evidence to support that law enforcement officers and the MOHLTC were called, and support was provided to resident #038, as per legislative requirement. Staff #165 did not provide any documentation related to the home's investigation and indicated that staff #129 was responsible to investigate the alleged abuse.

Staff #113 provided a copy of the CIS report when the inspector requested the home's investigation notes. As result, the home failed to investigate the above alleged emotional abuse. [s. 23. (1) (a)] (502)

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

Resident #006 was triggered from stage one for altered skin integrity, as the inspector observed altered skin integrity on resident #006 on an identified date.

Record review revealed that resident #006 had multiple identified altered skin integrity for the past 12 months and had been referred to specialized services on multiple occasions. Further record review home electronic documentation record PCC for an identified period of time failed to reveal any completed skin assessments by a member of the registered nursing staff.

Review of the resident #006's written plan of care for identified periods of time, failed to reveal a focus related to skin and wound.

In an interview, resident #006 told the inspector that he/she has an ongoing skin condition.

In interviews, staff #158 and #159 stated that resident #006 has had ongoing altered skin integrity. PSW #158 further stated that he/she had reported the altered skin integrity identified above to staff #116 on an identified date. In an interview, RPN #160 stated that he/she was aware of ongoing resident #006's altered skin integrity, and should have been included in resident #006's written plan of care.

In an interview, DOC #113 acknowledged that resident #006's plan of care was not based on an interdisciplinary assessment with respect to the resident #006's ongoing altered skin integrity. [s. 26. (3) 15.] (673)

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

On an identified date, a complaint was submitted to the MOHLTC related to food quality. The complainant reported that an identified resident was given sandwiches for lunch that were often stale with moldy spots on the bread.

On an identified date, the inspector observed a container of two per cent (2 %) skimmed milk served to resident at breakfast, and then stored in the refrigerator on the third floor servery after breakfast. Further observation of the above identified milk revealed that the fermentation process had started and the milk had expired on an identified date, which was four days past the expiry date.

In an interview, staff #163 stated that the milk was not “so bad” as it was only four days past the expiration date. He/she acknowledged that the milk was bubbling inside and should have been discarded during the daily inventory rotation by the dietary aide assigned to stock the refrigerator.

Staff #143 acknowledged that the milk with a past expiry date should have not been served to residents. He/she told the inspector that dietary aides are directed not to overstock the refrigerator and to rotate the inventory on hand in the serveries daily. [s. 72. (3) (a)] (502)

2. The licensee has failed to ensure that all food and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness.

On an identified date, a complaint was submitted to the MOHLTC related to food quality. The complainant reported that an identified resident was given sandwiches for lunch that were often stale with moldy spots on the bread.

On an identified date and time, the inspector observed salad, sandwiches, milk, salad dressing, cooked cheese pasta in the cooks' refrigerator. These food items were covered with black debris from mold, rust debris from the racks, and calcareous coating debris from the exhaust tube inside the refrigerator. Half an hour later, the inspector observed milk, jam, and left over food items placed on a red tray covered with mold in the third floor server's refrigerator.

Review of the weekly schedule for the month of August revealed that the refrigerator had been signed off as having been cleaned each week.

Staff #143 acknowledged that the tray had mold and should not be used to store food items. He/she further stated that dietary aides should clean all trays when cleaning the refrigerator. [s. 72. (3) (b)] (502)

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

On an identified date, a CIS was submitted to the MOHLTC, related to an incident of alleged staff to resident abuse. Review of the CIS revealed that on an identified date, staff #100 witnessed staff #111 act inappropriately toward resident #045 resulting in pain.

The inspector reviewed the abuse prevention training record of five staff, who were newly hired within the last six months. The inspector noted that five out of the five employees, including PSW #167, had not completed their training on the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Review of the home's abuse policy included in the new staff's orientation package revealed a two page document that outlined only the categories of abuse and a brief statement on zero tolerance and mandatory reporting.

In an interview, staff #167 stated that he/she had been working in the home for the past three months. Staff #167 further stated that he/she reviewed the abuse policy provided in the orientation package and had not completed the online training for abuse prevention until a day prior to this interview.

In an interview, staff #125, who is also the education leader in the home, stated that the home's abuse policy training included a declaration of understanding of the Abuse Policy included in the new staff orientation package, and online training courses. Staff #125 confirmed that four out of the five employees, including staff #167, had not completed the online training courses before they started performing their responsibilities in the home. Staff #125 further stated that the Abuse policy document included in the new staff orientation package is not the home's complete abuse policy; therefore, all five aforementioned staff had not been trained on the home's Abuse policy to promote zero tolerance of abuse and neglect of the residents.

In an interview, staff #113 acknowledged that the above mentioned staff should have completed the training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities. [s. 76. (2) 3.] (673)

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

**s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventive and remedial maintenance.

Resident #009 triggered from stage one for common areas disrepair.

On an identified date and time, the inspector observed corrosion and rust in resident #009's bathroom sink and the toilet base.

In an interview, staff #157 stated that he/she was not aware of corrosion and rust in resident #009's bathroom sink and toilet base. Staff #157 further stated that a preventative maintenance schedule for sinks in the home had not been developed.

In an interview, staff #140 who is also the designated lead for maintenance, stated that there is a schedule for preventative maintenance; however, staff #140 did not provide any documentation to support the existence of a preventative maintenance procedure or schedule in the home. [s. 90. (1) (b)] (673)

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee’s policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

On an identified date, a CIS was submitted to the MOHLTC, related to an incident of alleged staff to resident abuse. Review of the CIS revealed that on an identified date, staff #100 witnessed staff #111 act inappropriately toward resident #045 resulting in pain.

Review of the home’s investigation notes failed to reveal an analysis of the incident.

In an interview, staff #113 confirmed that an analysis of the alleged incident of abuse mentioned above, had not been completed. [s. 99. (a)] (673)

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident and/or the resident's SDM.

During the resident quality inspection (RQI) the mandatory medication inspection protocol was completed. As part of this inspection, medication incidents and errors were reviewed.

A review of the home's medication incident/errors binder revealed two medication incidents had occurred in the past six months.

A review of the home's Medication Incident and Reporting policy number RC-16-01-19,

last updated February 2017, revealed under procedures, point number six that staff are to communicate all medication incidents/adverse drug events to the POA/SDM/family.

a) A review of the medication incident report for resident #028 revealed a specified medication had been prescribed to be given for 21 days however was administered for 34 days. Further review of the medication incident report revealed that resident #028s substitute decision maker (SDM) had not been notified and a review of resident #028s progress notes also failed to reveal that the SDM had been notified.

In an interview, staff #124 stated he/she had not notified resident #028's SDM of the above mentioned medication incident.

b) A review of the medication incident report for resident #029 revealed an specified medication had been incorrectly packaged by the pharmacy. A review of the physician's order with an identified date, revealed an order for the above mentioned medication, to be given as one point two five (1.25) tablets by mouth, twice daily for a specified medical condition. The medication strip contained two tablets instead of only one and indicated 200 mg X 2.25 was to be given.

In an interview, staff #127 stated he/she had not notified resident #028's SDM of the medication incident. Staff #127 further stated this had been the first medication incident report he/she had completed and was not aware that resident #029s SDM required to be notified.

In an interview, staff #113 acknowledged that every medication incident involving a resident had not been reported to the resident and/or the resident's SDM. [s. 135. (1)] (589)

2. The licensee failed to ensure that every medication incident involving a resident is documented.

During the resident quality inspection (RQI) the mandatory medication inspection protocol was completed. As part of this inspection, medication incidents and errors were reviewed

A review of the home's medication incident/errors binder revealed two medication incidents had occurred in the past six weeks. Further review revealed that a quarterly review of all medication incidents had not been completed.

A review of resident #029's admission medication reconciliation and electronic medication administration record (e-MAR) revealed an order for a specified medication. The order read to give one point two five (1.25) tablets as prescribed. Further review of the medication strip revealed two tablets of 200 mg each had been packaged and to give two point two five tablets (2.25).

A review of resident #029's health record revealed he/she was admitted to the home on an identified date. That same day, resident #029 was transferred to hospital related to a change in his/her health status. Resident #029 was re-admitted to the home within 24 hours.

A review of the home's Medication Incident and Reporting, policy number RC-16-01-09, last updated in February 2017, revealed to communicate all medication incidents/adverse drug events. The policy defined a medication incident as, any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional practice, drug products, procedures, and systems and include prescribing, order communication, product labeling/packaging/nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

In an interview, staff #124 revealed that a nursing student had observed the packaging error the next day after admission, and he/she had instructed the nursing student to remove the extra tablet. Staff #124 further revealed that a medication incident report had not been completed. Staff #124 could not recall if he/she had notified pharmacy of the error. The nursing student was not available for an interview as he/she is no longer in the home.

In an interview, staff #127 stated five days after admission, he/she observed that the above mentioned medication appeared to be incorrectly packaged. RPN #127 further stated he/she had not encountered an incident like this before, so he/she reported it to the nurse manager (NM). Staff #127 stated the NM instructed him/her to complete an incident report, notify pharmacy and to place a change in medication sticker on the medication strip to alert other staff.
In an interview, staff #113 acknowledged that the home's expectation is for any medication incident to be reported on the day it is discovered and that staff #124 failed to ensure that the medication incident had been documented when discovered one day after admission. [s. 135. (1)] (589)

3. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident and/or the resident's SDM.

During the resident quality inspection (RQI) the mandatory medication inspection protocol was completed. As part of this inspection, medication incidents and errors were reviewed. A review of the home's medication incident/errors binder revealed two medication incidents had occurred in the past six months.

A review of the home's policy titled: Medication Incident and Reporting, policy number RC-16-01-19, last updated February 2017, revealed under procedures, point number six that staff are to communicate all medication incidents/adverse drug events to the POA/SDM/family.

4. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home, any changes and improvements identified in the review are implemented and that a written record is kept.

During the resident quality inspection (RQI) the mandatory medication inspection protocol was completed. As part of this inspection, medication incidents and errors were reviewed.

A review of the home's medication incident/errors binder revealed two medication incidents had occurred in the past six months. Further review revealed a quarterly review of all medication incidents had not been completed.

A review of the quarterly professional advisory committee (PAC) and quality improvement (QI) meeting minutes revealed medication incidents had been reviewed generally but not individually.

In an interview, the consultant pharmacist (CP) #135 stated quarterly reviews of medication incidents is an identified deficit in the home and a medication management system committee has been established to address this deficit.

In an interview, staff #113 acknowledged the home had not completed quarterly reviews of all medication incidents and adverse drug reactions as per legislative requirements. [s. 135. (3)] (589)

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents are provided training in skin and wound care.

Resident #006 was triggered from stage one for altered skin intergrity.

On an identified date, the inspector observed an altered skin integrity on resident #006.

Review of the staff training records for skin and wound care revealed that staff #114 had not completed the required training for skin and wound care until August 16, 2017.

In an interview, staff #126, who is also the skin and wound care program lead, confirmed that staff #114 had not completed the required training for skin and wound care until it was brought to the attention of the home by the inspector. [s. 221. (1) 2.] (589)

Issued on this 31st day of October, 2017

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

Original report signed by the inspector.

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) : JULIENNE NGONLOGA (502), BABITHA SHANMUGANANDAPALA (673), JOANNE ZAHUR (589)

Inspection No. / No de l'inspection : 2017_632502_0012

Log No. / No de registre : 017057-17

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

Report Date(s) / Date(s) du Rapport : Oct 10, 2017

Licensee / Titulaire de permis : CVH (no.1) LP
c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8

LTC Home / Foyer de SLD : CRAIGLEE NURSING HOME
102 CRAIGLEE DRIVE, SCARBOROUGH, ON, M1N-2M7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patrick Brown

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To CVH (no.1) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse. The plan shall include, but not be limited to the following:

- an ongoing monitoring system to ensure that recommendations made by specialized service such as Behavioural Support Outreach team (BSO) and Geriatric Mental Health Outreach Team (GMHOT) are implemented,

- the development and implementation of interventions that clearly describes how the home will protect resident #038 from abuse from resident #037, and

- the development and implementation of a process that clearly describes how staff investigate incidents of alleged abuse.

This plan is to be submitted via email to inspector Juliene.ngonloga@ontario.ca by October 17, 2017.

Grounds / Motifs :

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

On an identified date a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #011 told staff #165 and a Behaviour Support Outreach (BSO)'s nurse that he/she had voiced a specified threat toward resident #035. Resident #011 was re-approached and repeated this threat.

a) In an interview, resident #035 stated that he/she was involved in an altercation with resident #011 a few months ago, and that he/she was aware that resident #011 had made a specified threat toward him/her, but was not afraid of resident #011 as he/she can defend him/herself. Resident #035 further stated that he/she blames the management of the home, as they did not take the above incident seriously.

Review of resident #011's annual and quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) revealed that resident #011 had mild cognitive impairment, and exhibited specified responsive behaviours.

Review of resident #011's progress notes revealed that he/she had exhibited the above mentioned responsive behaviours on multiple occasions.

Record review and interviews with staff #166, #128 and #148 revealed that resident #011 was not closely monitored for two days within a specified period of time after the incident occurred.

b) In an interview, resident #011 stated that he/she was involved in a specified incident with resident #035 and that he/she had made specified threat toward resident #035.

On an identified date, staff #129 stated that specified interventions would be implemented to address resident #011's identified responsive behaviours.

Observation and interview with staff #133 revealed that the interventions identified by staff #129 were not implemented.

In interviews, staff #148 and #113 acknowledged that resident #035 was not protected from abuse by resident #011 as the above identified by staff 129 interventions were not implemented. [s. 19. (1)] (502)

2. On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date and time, resident #037 approached resident #038 and grabbed him/her resulting in an injury to resident #038.

In an interview, resident #038 stated that a few weeks ago, resident #037 exhibited a specified behaviour toward him/her which resulted in an injury.

Resident #038 told the inspector that this behaviour was constant, as both residents had been sharing the same room for the past three months.

Review of resident #037's plan of care revealed that resident #037 exhibited specified responsive behaviours towards other residents, and that staff were directed to move resident #037 to a more appropriate environment.

In an interview, staff #128 stated that on the date and time of the above identified incident, he/she observed resident #037 approach resident #038 and an altercation occurred, and both residents were redirected by staff #128. A few minutes later, resident #037 approached resident #038 and abused him/her resulting in an injury to resident #038. Staff #128 stated that if he/she had known that resident #037 would continue to exhibit the behaviour, he/she would have monitored resident #038 more closely to prevent further incident.

In an interview, staff #129 stated that he/she was aware of resident #037's responsive behaviour toward other residents, since the change in his/her medical condition. Staff #129, further stated that the specific interventions had been implemented.

In an interview, staff #113 acknowledged that abuse occurred, as staff did not ensure resident #038 was safely redirected away from resident #037 after the first incident. [s. 19. (1)] (502)

3. On an identified date, a critical incident report system was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of alleged staff to resident abuse. Review of the CIS and the home’s investigation notes revealed that on an identified date, resident #045 was exhibiting specified responsive behaviours during mealtime. When staff #100 entered the dining room to assess the resident, he/she witnessed staff #111 abuse resident #045 resulting in pain.

In an interview, staff #111 stated that he/she had asked resident #045 to stop exhibiting the specified responsive behaviour, but denied abusing resident #045.

In an interview, staff #100 confirmed that he/she had witnessed staff #111 acting inappropriately toward resident #045 the above mentioned incident.

In an interview, staff #129 stated that the home did not find evidence to support

the alleged abuse as staff #100 later retracted his/her statement. This contradicted staff #100's statement that he/she had never retracted his/her statement.

In an interview, staff #113 acknowledged that resident #045 was not protected from abuse by staff #111.

The severity of this incident is actual harm/risk as the resident sustained an injury. The scope of this incident is isolated as three residents were involved. The previous compliance history revealed ongoing noncompliance with VPC. As a result of this non-compliance with LTCHA 79/10, s. 19, a compliance order is warranted. [s. 19. (1)] (673)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that when a resident has not met his/her assessed daily fluid target for three consecutive days,
- the registered nursing staff complete a Nursing Hydration Assessment, and
- a referral is made to the registered dietitian and the home's physician as needed.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #015 was triggered from stage one for signs of dehydration.

As per O. Reg. 79/10, r. 68 (2)(d), every licensee of a long-term care home shall ensure that the programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Review of the home's Food and Fluid Intake Monitoring Policy #RC-18-01-01 dated February 2017, revealed that if after considering additional fluid intake, the resident still has not met his/her individual fluid target for three consecutive days, the registered nursing staff must complete a Nursing Hydration Assessment.

Review of resident #015's most recent written plan of care under the focus of Dehydration and Fluid maintenance revealed that resident #015 had an ongoing

fair fluid intake with a specified daily fluid requirement.

Review of resident #015's fluid intake for an identified period of time, revealed that on multiple occasions, resident #015's daily fluid intake was less than his/her daily fluid requirement for three consecutive days.

Review of resident #015's progress notes revealed that on an identified date the registered nursing staff had documented to increase resident #015's fluid intake. Three days after, the home's dietitian assessed resident #015 following a significant weight change for an identified period of time, and documented that resident #015 had poor to fair fluid intake and recommended a nutritional supplement. Thirteen days after, registered nursing staff documented that resident #015 looked weak and lethargic, on the next day, resident #015's fluid intake was less than his/her daily fluid requirement, and then he/she was line listed with a specified health condition. Resident #015 was assessed and signs and symptoms of the above specified health condition were identified.

On the same day, resident #015's primary physician was notified and he/she ordered a specified treatment for two days.

In an interview, staff #101 stated that he/she had not received a referral from the registered nursing staff related to the specified medical condition until after the above treatment was initiated.

In an interview, staff #112 stated he/she was aware that resident #015's fluid intake was less than his/her daily requirement for three consecutive days on multiple occasions. Staff #112 told the inspector that he/she had not completed the specified assessment for resident #015, and had not referred the resident to the registered dietitian or the physician as per home's protocol until a specified date, which was 44 days later.

In an interview, staff #113 acknowledged that the registered staff should have completed the specified assessment when resident #015's daily fluid intake was less than his/her daily requirement for three consecutive days; therefore, the home's Food and Fluid Intake Monitoring Policy was not complied with.

The severity of this incident is actual harm/risk as the resident became dehydrated. The scope of this incident is isolated to one resident. The previous compliance history revealed ongoing noncompliance with VPC. As a result of

this non-compliance with O. Reg. 79/10, r. 8, a compliance order is warranted.
[s. 8. (1) (a),s. 8. (1) (b)] (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure the safety of all residents. The plan shall include, but not be limited to the following:

- a multidisciplinary Behaviour Support Outreach (BSO) team that including in registered nursing staff, who are employee of the home,

- development and implement of a process that clearly describes how the home will prevent resident #011 from executing his/her threat toward resident #035,

- develop and implement a safety plan for resident #035,

- develop and implement a process that clearly outlines how the home will address resident #037's actions of abuse towards resident #038, and

- ongoing monitoring system to ensure the above mentioned process is evaluated for its effectiveness.

This plan is to be submitted via email to inspector juliene.ngonloga@ontario.ca by October 15, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours.

On an identified date, a CIS was submitted to the MOHLTC related to an incident of alleged resident to resident abuse. Review of the CIS revealed that on an identified date, resident #038 reported to staff #165 and an identified BSO nurse that resident #011 had voiced a specified threat toward him/her. On the same day, resident #038 told specialized service members that he/she did not want to be in the same room with resident #011, as result the home implemented specified interventions.

Record review revealed that the intervention specified above was recommended to be initiated immediately until re-assessment of resident #011.

On identified dates during mealtimes, observation of resident #011 revealed that one of the above intervention was not implemented.

In interviews, staff #167 and #168 stated that they only implement the above identified intervention when resident #011 exhibit identified responsive behaviours. In an interview, staff #143 told the inspector that staff are directed to implement the intervention recommended by the specialized team.

2. Record review revealed that the resident #011 had been identified as exhibiting specified responsive behaviour, and identified intervention were to be implemented until re-evaluation.

Record review on the home's electronic documentation system PCC revealed that on multiple occasions the interventions were not implemented while resident #038 had continued to share the same room with resident #011.

In interviews, staff #142 and #129 stated that the above identified interventions were in place for an identified period of time, which was 11 days prior to when resident #038 was provided with an alternate accommodation away from resident #011. Staff #129 further stated that all interventions should have remained in place until the specialized team reassesses resident #011.

3. In an interview five months after the first incident, resident #011 voiced identified responsive behaviours toward resident #035 and provide details of the specified threats he/she voiced five months earlier. Staff #129, who was present during the above interview, told the inspector that identified interventions would be implemented immediately.

On multiple occasions during the inspection, the inspector observed that the above identified interventions were not implemented for resident #011.

In interview, staff #148 and #133 confirmed that the above identified interventions were not implemented for resident #011 as they were not aware of the recommendations made by staff #129. Staff #133 further stated that resident #011 and #035 should not be left together unsupervised.

Staff #123 had not provided documentation to support that the above identified interventions had been re-evaluated prior to being discontinued. Therefore, the home failed to demonstrate that the interventions developed, after resident #011's specific threat toward resident #035, and after the safety concerns for resident #038 voiced by specialized service members, had not been implemented to assist residents #038 and #035 who are at risk of harm.

The severity of this incident is actual harm/risk as both residents were harmed as a result of resident #011's identified responsive behaviours and the home's failure to implement the required interventions. The scope of this incident is isolated, and the previous compliance history revealed previous non-compliance unrelated. As a result of this non-compliance with O. Reg. 79/10, r. 55, a compliance order is warranted. [s. 55. (a)] (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 24, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 10th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Julienne NgoNloga

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