Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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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
Feb 5, 2018	2018_643111_0001	023199-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

ELGINWOOD
182 YORKLAND STREET RICHMOND HILL ON L4S 2M9

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

LYNDA BROWN (111), CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

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): January 2 to 5, 2018 and January 9 & 10, 2018

The following critical incident and complaint inspections were completed concurrently during this RQI Inspection:

1. Critical Incidents:
-Log # 007469-17, 008123-17, 007693-17 & 010468-17 related to alleged staff to resident abuse and/or neglect.
-Log # 007494-17, 026765-17 related to alleged staff to resident improper care.
-Log # 024335-17 related to a medication incident.

2.Complaints:
-Log # 025498-17, 009468-17, 026609-17 & 022863-17 related to improper care (wounds, catheter, transferring).
-Log# 026499-17 related to alleged staff to resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), The Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Maintenance, Resident Services Coordinator (RSC), Recreation Manager, Resident Council president, Resident's and families.

During the course of the inspection, the inspector(s) completed a tour of the home, observed infection control practices within the home, observed a medication administration, observed a medication cart, reviewed health care records of current and deceased residents, Resident Council meeting minutes, Professional Advisory Committee meeting minutes, medication incidents, and relevant policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the written policy that promotes zero tolerance of

abuse and neglect of residents was complied with.

Related to log # 010468-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident. The CIR indicated on the same day and at a specified time, the Substitute Decision Maker (SDM) of resident #024 came to the home and found the resident sitting in a lounge with door closed, appeared neglected and also reported being neglected. The SDM reported the alleged staff to resident neglect to RPN #107.

Review of the licensee's investigation, review of the resident #024 health record, and interview of staff by Inspector #111 indicated:
-RPN #107 documented on the specified date, after receiving report at start of shift, received a verbal complaint from SDM of resident #024 regarding neglect. The SDM was upset and crying. The RPN assessed the resident and ensured the resident was provided with appropriate care. The RPN spoke to PSW #108 who was assigned to resident #024 and the PSW reported he/she was directed by RPN #115 to place the resident in the lounge. RPN #107 reported the allegation of staff to resident neglect to the RN and the on-call manager.
- PSW #108 was interviewed three days later and confirmed what was documented by RPN #107. The PSW indicated the resident was sleeping in the mobility aid, in night clothing and placed in lounge. The PSW indicated he/she was not familiar with resident #024 level of care.
-RPN #115 documented on the day of the incident, resident #024 was given a late breakfast, refused care, remained in night clothing, was loud and noisy when awake and placed in dining room for close monitoring.
-RPN # 115 was interviewed by the ED, 15 days after the allegation was received, indicated resident #024 had slept in close to lunch time, was calling out and refused care so was placed in mobility aid with night gown and covered with a sheet. The RPN indicated the resident was sleeping in dining room after lunch and suggested during shift report at 1430 hours to place the resident in a quiet place.
-Interview with PSW #123 by Inspector #111, indicated on the identified date, resident #024 had slept all morning. The PSW indicated the resident refused care and was placed in a mobility aid in night clothing for lunch and was reported to RPN #115.
-Interview with ED by Inspector #111, indicated RPN #115 was not interviewed until 10 days later as the RPN was reluctant to come in for an interview. The ED could not provide documented evidence or indicate why PSW #123, RPN #107 or RN #122 were

not interviewed or any other actions taken.

Review of the nursing staffing schedule for a two week period in 2017 indicated the following:
-On a specified date of the allegation, RPN #115 and PSW #123 both worked the day shift. PSW #123 was assigned to provide care to resident #024. RPN #107 and PSW #108 worked the evening shift. PSW #108 was assigned to provide care to resident #024. RN #122 was the RN in charge of the building on the evening shift.
-RPN #115 was not interviewed until ten days later.
-PSW #108 worked and continued to provide care to residents on two specified dates and was not relieved of duty until two days later.

Review of the licensee's policy "Resident Non-Abuse" (ADMIN1-P10-ENT) reviewed August 31, 2017 indicated if there is any allegation towards a staff member, they will be suspended on administrative leave with pay immediately until an investigation is complete. Under section Investigation of Abuse or Neglect (ADMIN1-010.02) indicated an immediate and thorough investigation of the reported alleged abuse or neglect will be initiated by the home's ED or designate. The resources Tool Kit for Conducting an Alleged Abuse Investigation may be referenced. Under the Tool Kit, under step two: identify and interview the accused, identify persons involved in the incident. Under step six: identify and interview any additional potential witnesses by reviewing the staffing schedules during the time frame of the alleged incident. Obtain statements and conduct interviews with those identified.

The licensee failed to follow the licensee's Resident Non-abuse prevention policy as all staff involved were not relieved of duty pending the immediate investigation and the investigation was completed thoroughly, as all staff who potentially witnessed the incident, were not interviewed. [s. 20. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 026499-17:

A written complaint was received by the SDM of resident #023 to the home on a specified date regarding two separate alleged incidents: improper care and violation of the resident's rights. The first incident occurred over two separate days when the resident was not returned to bed as requested by the resident. The second incident occurred approximately one week before when the resident reported to PSW #127 regarding a PSW refusing to provide the resident with their name when the resident had concerns with personal care.

Review of the progress notes for resident #023 during a specified month in 2017 indicated on a specified date and time, RPN #126 documented receiving a concern from PSW #127 for resident #023 regarding care provided by PSW #124. PSW #127 indicated PSW #124 had refused to provide their name to resident #023 while providing care. The resident "perceived [PSW #124] as being angry and inpatient" and requested that the PSW did not provide care in the future.

Review of the licensee's investigation indicated the investigation was completed immediately after the written complaint was received from the SDM of resident #023, but was ten days after the initial verbal complaint was received by the resident. The investigation had no documented record to indicate who the staff member was involved in the first allegation of improper care or action taken to prevent a recurrence.

Review of the PSW schedule indicated PSW #124 worked on the identified date of the allegation and continued to work and provide care to residents on three separate dates until the PSW was suspended pending the investigation, ten days later.

Interview with ADOC indicated she recalled that PSW #131 was the staff member involved in the first allegation and recalled speaking with PSW #131. The ADOC indicated she spoke to resident #023 and PSW #127 on the following day when the complaint was received but had no documented evidence to support this or actions taken with PSW #131 or PSW #127.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log #007469-17:

Review of the critical incident report (CIR) indicated on a specified date in 2017, there was an allegation of staff to resident abuse towards four residents (resident #023, #029, #030 & #031) by PSW #133. The CIR indicated all residents and/or SDMs were notified of the allegations. Review of the health care records for resident #030 and #031 had no documented evidence to indicate the SDMs was notified of the outcome of the investigation.

Review of the licensee's investigation indicated there was no documented evidence to indicate the SDM's of resident #030 & #031 were notified of the outcome of the investigation.

Interview with the ED and ADOC by Inspector #111, indicated they were unable to provide documented evidence that the SDMs of resident #030 & #031 were notified of the outcome of the investigation into the alleged staff to resident abuse that was determined to be founded.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the resident and the SDM, if any, are notified of the results of the licensee's investigation into alleged, suspected or witnessed incidents of abuse and/or neglect, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Interview with the ED by Inspector #111, indicated that all verbal and written complaints received by the licensee related to abuse and/or neglect are not included in their complaints report log. The ED was unable to provide documented evidence of a review and analysis related to trends at least quarterly for allegations, suspicions or witnessed incidents of abuse and/or neglect for 2017.

Review of the complaints service log for 2017 indicated no documented evidence of the following verbal and/or written complaints received:
-Re: log # 007693-17 (CIR) a verbal complaint from SDM of resident #023 who reported an alleged staff to resident verbal abuse.
-Re: log # 010468-17 (CIR) a verbal complaint from SDM of resident #024 who reported an alleged staff to resident neglect.
-Re: log # 008123-17 (CIR) a verbal complaint from resident # 006 who reported an alleged staff to resident physical abuse resulting in injury.
-Re: log # 026499-17 a written complaint from SDM of resident #023 who reported an alleged staff to resident emotional abuse and improper care.
-Re: log # 007469-17(CIR) a written complaint from an anonymous student who reported witnessing a staff member being verbally, physically and emotionally abusive towards residents and resident #023.

There was no documented record of complaints received (verbal and/or written) to indicate they were reviewed and analyzed for trends, at least quarterly. There was no documented evidence of the results of the review and analysis that were taken into account in determining what improvements are required in the home.

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 documented record of complaints received related to alleged, suspected or witnessed abuse and/or neglect is documented and reviewed for trends at least quarterly; the results of the review and analysis are taken into account when determining what improvements are required in the home, and a written record is kept of each review and the improvements made., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that the drugs administered to resident #043 had been prescribed for the resident.

Related to log # 024335-17:

Resident #043 was administered another resident's medication in error on a specified date and time. The medication administered to resident #043 was a specified dose of a narcotic analgesic and a regular analgesic resulting in a change in condition and the resident #043 being transferred to the hospital for further assessment.

The plan of care for resident #043 indicated diagnoses which included cognitive impairment. The plan of care for Resident #043 indicated that extensive support was required for all activities of daily living (ADL's) and was a medium risk for falls.

Review of the licensee's investigation into the medication incident involving resident #043 by inspector #194 identified:
-RPN #116 failed to properly identify the resident prior to administrating medications.
-RPN #116 immediately identified the medication, notified the Physician, pharmacy, SDM and Executive Director (ED).
-Physicians orders were received to monitor the resident for 24 hours and was placed on hourly monitoring of resident #043.
-The following day, at a specified time, resident #043 demonstrated a change in condition, the physician was called and orders received to send the resident to the hospital for assessment. The resident returned later that day and no further negative affects from the medication incident.

Interview with ADOC and Administrator was completed by inspector #194, related to the medication incident and confirmed that RPN #116 no longer worked in the home.(194)

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 administered to residents as prescribed., to be implemented voluntarily.

WN #6: 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:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure the resident's right to be told who is responsible for and who is providing the resident's direct care was respected and promoted.

Related to log # 026499-17:

On a specified date in 2017, a verbal complaint was received by the home by resident #023 regarding a violation of the resident's right to be told who was providing their care. A written complaint was also received by the home regarding the same allegation, ten days later by the SDM of resident #023.

Review of the licensee's investigation into the allegation indicated PSW #124 was involved in the allegation and the licensee concluded the allegation was founded. The PSW received disciplinary action as a result.

Review of the staff training records and PSW #124 employee file indicated the staff member had received annual training for the past three years on resident rights, including 2017, and was aware of the resident's rights.

Interview with ED and ADOC by Inspector #111 confirmed the staff member (PSW #124) had violated resident #023 right to be told who was providing care for them and was aware of the resident's rights as the staff member had been provided with annual retraining on resident's rights and also had to sign a form indicating the same in 2017. [s. 3. (1) 7.]

WN #7: 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. (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).

Findings/Faits saillants :

The licensee failed to ensure that the SDM, if any, and the designate of the resident/SDM had been given an opportunity to participate fully in the development and implementation of the plan of care related to wound care.

Related to log # 025498-17:

A complaint was received by the Director from family of resident #044 indicating that the SDM was not notified of a wound to a specified area that occurred on a specified date in 2017.

Interview with RPN #130 was conducted by Inspector #194, related to resident #044's wound that was identified on a specified date in 2017. RPN #130 indicated the wound treatment was provided to the wound on the specified date but the SDM was not notified of the wound or treatment.

Interview with physician was conducted by Inspector #194, related to resident #044. The physician indicated that he did not notify the SDM of resident #044's of the wound in a specified date in 2017.

Review of the clinical health records for resident #044, including physician's order for the treatment of the wound on a specified date in 2017, wound care assessments and Treatment Administration Records (TARS) indicated documentation of treatment provided on three separate dates in 2017 related to the wound, which included a referral to wound care Nurse, but had no documented evidence the SDM was notified of the wound and treatment until six days later.(194)

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 010468-17:

A critical incident report (CIR) was submitted to the Director on a specified date in 2017 for an alleged staff to resident neglect incident. The CIR indicated that two days before, at a specified time, the SDM of resident #024 reported to RPN #107 an allegation of staff to resident neglect.

Review of the licensee's investigation and review of the health care record of resident #024 indicated on a specified date and time, the SDM of resident #024 came in to visit the resident and reported the alleged staff to resident neglect to RPN #107. RPN #107 documented the reported the verbal complaint of alleged neglect, and indicated the RN and manager were notified.

Interview with RPN #107 by Inspector #111 indicated the RPN notified RN #122 of the verbal complaint from family of staff to resident neglect. The RPN also indicated the RPN attempted to contact the on-call manager but there was no answer and had to leave a voice message.

Interview with RN #122 by Inspector #111 indicated he/she could not recall receiving a report of staff to resident neglect towards resident #024 from RPN #107.

Interview with the ED indicated the CIR was completed by the former DOC but the ED was aware of the allegation. The ED indicated the DOC became aware of the allegation (via a voice mail) that was received two days later when the DOC returned to work. The ED indicated the DOC reported the allegation to the Director at that time.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

The licensee failed to ensure the resident admission care plan included, at a minimum, the following with respect to the resident: 2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. 3. The type and level of assistance required relating to activities of daily living. 4. Customary routines and comfort requirements. 5. Drugs and treatments required.

Related to Log # 010468-17:

Review of the health care record for resident #024 indicated the resident:
- was admitted on a specified date in 2017 with diagnoses that included cognitive impairment. The resident's SDM indicated at the time of admission, the resident was mobile with use of a mobility aid and would require anti-anxiety medication for a few nights until the resident settled into the new environment. The physician was notified and an order was received for specified dose of anti-anxiety every six hours as needed for

agitation/anxiety.
-the following night, the resident was demonstrating signs of anxiety, placed in a mobility aid and given the anti-anxiety medication with good effect. Approximately six hours later, (in the morning), the resident was given the anti-anxiety medication for increased agitation. Approximately six hours later (in the afternoon), the resident was given the anti-anxiety medication for agitation. The following shift, the resident had remained in bed sleeping and had a poor appetite at supper.
-the following day, during the night, the resident began demonstrating signs of agitation and anxiety. The resident was provided with reassurance and given the anti-anxiety medication with good effect. Approximately eight hours later, RPN #115 indicated the resident had slept in, was given a late breakfast, refused care and remained in night clothing during the day shift. The RPN documented the resident began demonstrating responsive behaviours of agitation and anxiety.
The resident had requested to speak to family. The resident was provided support and then placed in the dining room for close monitoring. Approximately three hours later, the family came in to visit and found the resident neglected in a lounge with the door closed.

Review of the 24 hour admission care plan for resident #024 indicated the resident:
-could speak and understand English but also spoke a second language and had cognitive impairment.
-demonstrated responsive behaviours that included agitation and anxiety.
-required one staff assistance with all activities of daily living (ADLs), and was independent with use of two identified assistive devices.
-had pain but no indication of type, location or interventions to manage the pain.

The 24 hour admission care plan failed to indicate any potential behavioural triggers, and safety measures to mitigate those risks. The resident had demonstrated responsive behaviours of agitation and anxiety, which included disrupted sleep, and the only intervention identified was the use of an anti-anxiety medication at a specified dose every six hours for anxiety and agitation. The type and level of assistance required relating to ADL's indicated independent with mobility aid, but no indication when the second mobility aid was to be used or why, despite the SDM indicating the resident only used one of the specified mobility aids. The resident's customary routines and comfort requirements were not indicated or any interventions to manage same.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

The licensee has failed to ensure that the licensee respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #194 reviewed the minutes of the Resident Council in 2017. The minutes identified a written concern that was brought forward during a specified month related to staffing in the home. A response to the concern by management was provided eight days later.

During separate interviews with ADOC and Recreation Manager on January 9, 2017 by Inspector #194, indicated the concern was documented immediately and the licensee's response was completed within 10 days of the identified concerns. Both ADOC and Recreation Manager verified that the Resident Council was not informed of the response until the next Resident Council Meeting 28 days later. (194)

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

Related to log # 010468-17:

A critical incident report (CIR) was submitted to the Director on a specified date in 2017 for an alleged staff to resident neglect incident. The CIR indicated that two days before, at a specified time, the SDM of resident #024 reported to RPN #107 an allegation of staff to resident neglect. The CIR identified PSW #108 and RPN #107 as present and/or discovered the incident.

Review of the licensee’s investigation, review of the health care record of resident #024 and interview with staff indicated that RPN #115, PSW #123 and RN #122 were also present and/or discovered the incident and were not indicated on the CIR.

2. The licensee has failed to ensure that if unable to provide a report within 10 days, that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to log # 026499-17:

A written complaint was received by the licensee from the SDM of resident #023 on a specified date in 2017, regarding an alleged staff to resident emotional abuse and improper care. The licensee provided a written response to the SDM's written complaint. The licensee provided the Director a copy of the written complaint and the response to the SDM but no critical incident report was submitted to the Director which would include: the dates in which the allegations were made, the names of the staff involved in the allegation, actions taken as a result of the investigation or the outcome of the investigation.

Interview with the ED by Inspector #111 confirmed that no CIR was submitted to the Director regarding the alleged staff to resident abuse and improper care towards resident #023.

Issued on this 5th day of February, 2018

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

Original report signed by the inspector.