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
Jun 13, 2018	2018_598570_0006	004376-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

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

SAMI JAROUR (570), DENISE BROWN (626), JENNIFER BATTEN (672)

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): March 5-9, 12-16, 19-23 and 26, 2018

The following complaints and Critical Incident Reports (CIR) intakes were completed during the RQI Inspection:

Complaints:
- Logs #010523-16 and #032238-16 - Complaints specific to alleged staff to resident abuse;

- Log #024209-16 – Complaint specific to improper care of a resident; and
- Logs #030024-16 and #032093-16 - Complaints specific to alleged staff to resident abuse.

Critical Incident Reports (CIR):
- Log #009693-16 - CIR specific to alleged staff to resident abuse/neglect;
- Log #035288-16 - CIR specific to alleged neglect of a resident;
- Log #035305-16 - CIR specific to alleged staff to resident abuse;
- Log #021836-16 - CIR specific to improper care of a resident resulting in an injury;
- Logs #019201-16, #019951-16, and #020396-16 specific to medication incidents/adverse drug reaction; and
- Logs #024441-16, #027570-16, #028507-16, #006548-17, #012799-17 and #015348-17 specific to incidents that caused injury to residents for which the residents were taken to hospital, and which resulted in a significant change in residents' health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), MDS-RAI Coordinator, Maintenance Supervisor, Registered Dietitian, Dietary Manager, Dietary Supervisor, Dietary Aides, Activity Aide, President of Residents' Council, residents and family members.

During the course of the inspection, the inspectors toured residents' rooms and common areas, observed resident to resident interactions and staff to resident interactions during the provision of care. The inspectors observed infection control practices and medication administration. The inspectors reviewed clinical health records, the licensee's investigation documentation and policies related to bed rails, and medication incident and reporting.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **8 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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that resident #027's right to be properly sheltered,

fed, clothed, groomed and cared for in a manner consistent with their needs was fully respected and promoted.

Related to Log #024209-16:

Resident #027 was admitted to the home on a specified date with medical diagnosis that affected mobility and swallowing. Resident #027 was not cognitively impaired, and as a result of the medical conditions, resident #027 was at a nutritional risk.

A complaint was called into the INFOLine by resident #027's Substitute Decision Maker (SDM) on a specified date. The complainant reported that over the past few months, resident #027 had been experiencing some eating difficulty, therefore had been assessed as requiring an identified diet. Resident #027 did not enjoy identified foods, and would refuse to eat, unless preferable textured foods were served. According to the complainant, due to liability concerns, the management team and the dietary department refused to provide resident #027 with the resident's preferred texture of foods. The family were directed to bring in foods that the resident preferred and in the event that the family was not in the home, the home would serve the resident prescribed menu items. On a specified date, resident #027 was eating foods of their preference, which had been brought in by family, and experienced a negative episode.

A review of the progress notes indicated that on a specified date, an interdisciplinary meeting was held, and resident #027 was assessed to receive an identified diet, with preferred choices of food.

During an interview, the registered dietitian (RD) indicated that following the meeting held on a specified date it was agreed that resident #027 would continue to receive an identified diet when a family member was not present. The RD further indicated a three week menu was provided to resident #027's family member, to review with the SDM and resident #027, to choose identified food choices, which resident #027 had been able to tolerate in the past. The RD indicated these choices were not to include specified food items.

Inspector #672 reviewed the written plan of care, which revealed resident #027 was to receive an identified diet choices, based on family request, only when they were present. There were no clear directions provided for what foods were to be served when resident #027's family was not present.

Review of the progress notes for an identified period, revealed that on multiple occasions, resident #027 and the SDM made complaints that resident #027 continued to not receive an identified diet choices when requested.

During interviews, the RD and the food services manager (FSM) indicated they were both aware that following the meeting held on a specified date, there continued to be issues with resident #027 not receiving the requested diet choices, and confusion between staff, related to what diet choices resident #027 was permitted to receive. The RD further indicated belief that this was related to the staff being uncomfortable with resident #027 receiving identified diet, and that no one wanted to be responsible for giving resident #027 a food item which may cause a negative outcome.

The licensee had failed to ensure that resident #027's rights to be properly fed and cared for in a manner consistent with their needs were fully respected and promoted, by not ensuring that resident #027 received an identified diet requested, after making an informed decision regarding their choices. (672) [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs was fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (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 :

1. The licensee had failed to ensure that the written care plan for each resident, sets out the planned care for the resident.

Related to resident #004:

During stage one of the RQI, the use of bed rails by resident #004 was triggered as a potential restraint.

Review of the clinical records for resident #004 indicated the resident was admitted to the home on an identified date, with multiple diagnoses that affect mobility.

On March 6 and 8, 2018, Inspector #626 observed resident #004's bed with specified bed rails in the up position.

On March 13, 2018, Inspector #570 observed resident #004's room; specified bed rails noted in up position. In an interview with Inspector #570, the resident indicated that they use the bed rails when getting out of bed and sometimes the bed rails are up so that they do not fall out of bed.

The current written plan of care for resident #004 was reviewed by Inspector #570. The plan of care indicated the resident participates in bed mobility and one staff to provide weight bearing assistance. The plan of care review did not indicate that the resident uses

bed rails.

During an interview, PSW #115 indicated to Inspector #570 that resident #004 used specified bed rails; PSW #115 further indicated that the resident had the bed rails since admission date and that the resident used the rails for bed mobility and transfer.

During an interview, RPN #116 indicated to Inspector #570 that resident #004 used specified bed rails to assist in transfer. RPN #116 confirmed to Inspector #570 that the use of bed rails was not included in resident #004's written plan of care.

During an interview, the Director of Care (DOC) indicated to Inspector #570 that it is an expectation that when bed rails are used by a resident, they should be included in the resident's written plan of care.

The licensee did not ensure that the written care plan for resident #004 set out the planned care for the resident, specific to the use of bed rails. [s. 6. (1) (a)]

2. Related to resident #010:

During stage one of the RQI, the use of bed rails by resident #010 was triggered as a potential restraint.

Review of the clinical records for resident #010 indicated the resident was admitted to the home on an identified date with multiple diagnoses including cognitive decline.

On March 6, 2018, Inspector #626 observed resident #010's bed with specified bed rails in the up position.

On March 8, 2018, Inspector #570 noted resident #010's bed with specified bed rails in the up position.

The current written plan of care for resident #010 was reviewed by Inspector #570. The plan of care directed staff to provide one staff assistance for transfers. The plan of care review did not indicate that the resident used bed rails.

During separate interviews, PSW #111 and #114 indicated to Inspector #570 that resident #010 had specified bed rails attached to bed; both PSWs indicated no awareness that the resident uses those bed rails.

During an interview, RPN #112 indicated to Inspector #570 that resident #010 had specified bed rails used for bed mobility. The RPN confirmed to Inspector #570 that the use of bed rails was not included in the resident's written plan of care.

During an interview, RN #113 indicated to Inspector #570 that specified bed rails are used in the home as they come with the bed and used to assist with transfer for safety. The RN further indicated that the bed rails would be included in the written plan of care only if they are considered restraints.

During an interview, the Director of Care (DOC) indicated to Inspector #570 that the bed rails used at the home are considered assist rails used to assist residents in transfer and bed mobility; the DOC further indicated that use of bed rails should be included in the written plan of care.

The licensee did not ensure that the written care plan for resident #010 set out the planned care for the resident, specific to the use of specified bed rails. [s. 6. (1) (a)]

3. Related to resident #005:

During stage one of the RQI, the use of bed rails by resident #005 was triggered as a potential restraint.

Resident #005 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

On March 06, 09 and 13, 2018, Inspector #626 observed resident #005's bed with specified bed rails which were found in the up position.

A review of the resident's written plan of care on March 7, 2018, indicated that the specified bed rails were not documented in the written plan of care.

In an interview with Inspector #626, PSWs #125 and #129 indicated that the bed rails were used for the resident's safety.

During an interview with Inspector #626, RPN #130 indicated that the bed rails were used to keep the resident in bed. The RPN also indicated, that the bed rails and their use, was not noted in the resident's written plan of care.

In an interview with Inspector #626, the DOC indicated that the bed rails and its use should have been documented in resident #005's written plan of care.

The licensee did not ensure that the written care plan for resident #005 sets out the planned care for the resident, specific to the use of the two quarter bed rails. [s. 6. (1) (a)]

4. Related to resident #005:

During stage one of the RQI, the use of a mobility device with reclining feature by resident #005 was triggered as a potential restraint.

Resident #005 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

On March 06, 08 and 09, 2018, Inspector #626 observed resident #005 seated in a mobility device, which was in the reclining position.

A review of the resident's written plan of care on March 07, 2018, did not indicate that resident #005's mobility device was to be placed in the reclining position, as an intervention, or as a Personal Assistance Service Device (PASD).

In an interview with Inspector #626, PSW #129 indicated that the mobility device with reclining feature was used as a PASD for resident #005. The PSW also indicated, that resident #005 had the tendency to lean forward while and would slide out while seated in the mobility device, if not placed in a reclined position. In another interview with Inspector #626 on March 09, 2018, PSW #125 indicated that the mobility device with reclining feature was used as a PASD for resident #005, as it prevented the resident from falling forward.

In an interview with Inspector #626, RPN #130 indicated not being aware of the reason for the use of the reclining feature of the mobility device. The RPN also indicated that the plan of care documented the mobility device to be used for locomotion but did not have any information about reclining when using the mobility device for use as a PASD.

During an interview with Inspector #626, the DOC indicated that the mobility device with reclining feature is a PASD, as the resident does not have good trunk control. The DOC also indicated that the PASD should have been documented in the plan of care.

The licensee had failed to ensure that the written plan of care for resident #005, set out the planned care for the resident, specifically related to the use of a reclining feature of the mobility device. [s. 6. (1) (a)]

5. The licensee had failed to ensure that the written plan of care for resident #036 set out clear directions to staff and others who provided direct care to the resident, specifically related to responsive behaviours.

Related to Log#035305-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to an allegation of staff to resident abuse, which occurred on an identified date. The CIR indicated that during a specified meal on an identified date, resident #032 reported that PSW #140 was observed to act inappropriately toward resident #036. The CIR further indicated that resident #036 was exhibiting an identified responsive behaviour towards PSW #140 at the time of the incident.

Resident #036 was admitted to the home on an identified date, with medical diagnosis which included cognitive decline.

A review of the progress notes for an identified period, revealed that resident #036 exhibited identified responsive behaviours almost daily.

A review of resident #036's written plan of care, in place at the time of the incident, did not identify that resident #036 exhibited any identified responsive behaviours. There were no goals or interventions listed which set out clear directions for front line staff to follow, related to any identified responsive behaviours.

During an interview , RAI Co-ordinator #153 indicated that the expectation in the home was that as soon as staff observed a resident exhibiting a responsive behaviour, the written plan of care was to be updated, identifying the behaviour, along with the goals and interventions for the resident, and provide staff with clear directions to follow when the responsive behaviour was exhibited.

During an interview, the DOC indicated that the expectation was that the written plans of care were to be updated when it was observed that a resident was exhibiting a new responsive behaviour, or that an intervention, focus or goal was no longer effective or

relevant. The DOC reviewed the written plan of care for resident #036 which was in place at the time of the identified incident, and indicated that the written plan of care did not identify the responsive behaviours exhibited by resident #036, or provide any directions to staff, in relation to how to manage the exhibited responsive behaviours. [s. 6. (1) (c)]

6. The licensee had failed to ensure that resident #029 and resident #029's SDM, were provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Log #030024-16:

On an identified date, resident #029's SDM contacted the Action Line with the MOHLTC, to report allegations of staff to resident abuse directed towards resident #029, which the SDM felt was retaliation as a result of another allegation submitted on a previous identified date, which alleged abuse from PSW #159, towards resident #029. Resident #029's SDM alleged that following the first incident, a request was made to the DOC that PSW #159 no longer be assigned to resident #029. On an identified date, resident #029's SDM stated that the change to resident #029's assignment had not been completed, that PSW #159 continued to be assigned to resident #029, and as a result, PSW #159 was making comments to resident #029 that were inappropriate.

Resident #029 was admitted to the home on an identified date, with medical diagnosis which included cognitive decline.

During an interview, resident #029's SDM indicated that following the allegation of staff to resident abuse involving PSW #159, a request was made to the DOC that PSW #159 no longer provide care to resident #029. Resident #029's SDM further indicated the DOC had informed SDM that the request would be very difficult to implement, due to other scheduling concerns in the home, resident #029's SDM felt that the schedule was more important than the residents or family member's feelings and requests. Resident #029's SDM indicated that due to PSW #159 not being removed from resident #029's assignment following the first allegation, resident #029 was subjected to retaliation from PSW #159, which included abuse, and that the allegations of abuse had been reported to the DOC.

During an interview, the DOC indicated that they believed that following the first incident, PSW #159 had been removed as the primary PSW for resident #029, but continued to assist as the secondary PSW. The DOC further indicated that the secondary PSW would

assist with tasks such as transfers and repositioning. The DOC indicated that the ADOC had completed the internal investigation into the allegation, therefore it would have been the ADOC who made the changes to resident #029's assignment.

During an interview on ADOC #158 indicated that following the first allegation, PSW #159 had not been removed from resident #029's assignment, and continued to act as the primary PSW until resident #029's SDM brought the concern forward again on an identified date. The ADOC indicated that PSW #159 had not been removed from resident #029's assignment following the allegation, due to logistical concerns with the PSW schedule which would have been caused by removing resident #029 from PSW #159's assignment.

During an interview, the DOC indicated that the expectation in the home was that if a resident or SDM requested that a PSW no longer be assigned to provide care following an allegation of abuse or neglect, that the PSW would be removed from the resident's assignment.

The licensee had failed to ensure that resident #029's SDM and the resident were provided the opportunity to participate fully in the development and implementation of the plan of care, ensuring that PSW #159 was no longer assigned to act as resident #029's primary PSW and provide care, following an allegation of staff to resident abuse. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care for each resident includes the planned care for the resident, clear directions to staff and others who provide direct care to the resident, and Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Related to resident #004:

During stage one of the RQI, the use of bed rails by resident #004 was triggered as a potential restraint.

Review of clinical records for resident #004 indicated the resident was admitted to the home on an identified date, with multiple diagnoses that affected mobility.

On March 6, 2018, during an observation, Inspector #626 observed resident #004's bed with specified bed rails in the up position.

On March 8, 2018, Inspector #570 noted resident #004's bed with specified bed rails in the up position.

On March 13, 2018, Inspector #570 observed resident's room; specified bed rails noted up in the transfer position at head of bed; the resident indicated to the inspector that they use the bed rails when getting out of bed and sometimes the bed rails are kept up so that they do not fall out of bed.

Review of clinical records of resident #004 did not include any documentation that the resident was assessed and their bed system evaluated to minimize risk to the resident when the bed rails were used.

During an interview, the Director of Care (DOC) confirmed to Inspector #570 that the resident was not assessed nor their bed system was evaluated when the bed rails were used. [s. 15. (1) (a)]

2. Related to resident #010:

During stage one of the RQI, the use of bed rails by resident #010 was triggered as a potential restraint.

Resident #010 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

On March 6, 2018, during an observation, Inspector #626 observed resident #010's bed with specified bed rails in the up position.

On March 8, 2018, Inspector #570 observed resident #010's bed with specified bed rails in the up position at the head of bed.

Review of clinical records of resident #010 did not include any documentation that the resident was assessed and their bed system evaluated to minimize risk to the resident when the bed rails were used.

During an interview, the Director of Care (DOC) confirmed to Inspector #570 that resident #010 was not assessed nor their bed system evaluated when the bed rails were used. [s. 15. (1) (a)]

3. Related to resident #005:

During stage one of the RQI, the use of bed rails by resident #005 was triggered as a potential restraint.

Resident #005 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

On March 06, 09 and 13, 2018, Inspector #626 observed resident #005's bed with specified bed rails which were found in the up position.

In a review of the resident's electronic and hard copy medical records, there was no documentation found, to indicate that the resident was assessed and the bed system was evaluated in order to minimize risk to the resident.

In an interview with Inspector #626, PSW #125 indicated that the bed rails prevented the resident from falling out of bed. In another interview on the same date, PSW #129 indicated that bed rails were used for the resident's safety.

During an interview with Inspector #626, RPN #130 indicated that the bed rails were used to keep the resident in bed. The RPN also indicated not being aware, if the resident was assessed for the use of the bed rails or where this information would be documented.

In an interview with Inspector #626, the DOC indicated that there was no current process used in the home, to assess residents for the use of bed rails and that there were plans to start a process.

The licensee had failed to ensure that resident #005 was assessed and the bed system was evaluated in accordance with evidence-based practices and prevailing practices, to minimize risk to the resident when bed rails were used. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents using bed rails are assessed and their bed systems evaluated in accordance with evidence-based practices to minimize risk to residents, to be implemented voluntarily.

WN #4: 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 had failed to ensure that the home, furnishings and equipment are maintained in safe condition and in good state of repair.

During the initial tour of the building, the following was observed;

In an identified residents' home area:
In the Spa Shower room, a small area of water stain was located on the ceiling over the counter. In the washroom between two identified rooms, there was a brown water stain on the ceiling above the toilet. In the adjoining Spa Tub room, there was also a small area of peeling plaster on the ceiling.

In an identified residents' home area:
In the Spa Shower room, a brown water mark and peeling plaster was observed on the ceiling throughout the room. There was also a large area of torn and missing Linoleum around floor drain in front of the sitting tub-like shower stall. In the washroom between two identified rooms, a brown water stain was also observed on ceiling tile.

In an identified residents' home area:
In the Spa Shower room, there was a small water mark on the ceiling over the counter. In the washroom between two identified rooms, a large ceiling tile was missing over the toilet, leaving the area opened.

In an identified residents' home area:
In the Spa Tub room, there was a large brown water stained area on the ceiling as well a moderate size open area over the tub and peeling plaster was noted. There was also a large ceiling tile missing close to the tub, leaving an open area to the ceiling. In the Spa

Shower room, there was a dark water stain on ceiling and peeling plaster was also noted.

In an identified residents' home area:
In the Spa Shower room, a small water mark was observed on the ceiling over the counter. In the washroom between Spa rooms a brown water stain was also observed on the ceiling tile above the sink.

In an identified residents' home area:
In the washroom between Spa rooms, a grey stain was observed, on the ceiling tile above the sink. In Spa Shower room, there was also a water stain on the ceiling and a ceiling tile was missing and exposed wires and pipes in the ceiling.

In an interview by Inspector #626 with PSW #115, regarding a specific shower room, the PSW indicated that there was a previous flood but was uncertain of when it had occurred.

In an interview with Inspector #626, Maintenance Supervisor #101 confirmed there was a few areas of the building that required the roof to be replaced and that areas identified were damaged related to a water leak. Maintenance Supervisor #101 also indicated that the delay in repair was because it has taken one summer to repair one section of the roof and also because of the cost. Maintenance Supervisor #101 further indicated that ceiling tiles were routinely changed but would become damaged again after a rain fall.

During an interview, with Inspector #626, the Administrator indicated being aware that there were concerns with the roof of the building leaking. The Administrator also indicated, that the roof was being repaired a block at a time.

On identified date during this inspection, Inspector #626 toured and inspected all three floors of the home with each floor containing two resident home areas and resident service areas. During this inspection the following observations were made;

In an identified floor:
On an identified resident home area, Inspector #626 observed water marks with brownish stains on the ceiling in multiple areas including entrance of the home area, residents’ lounge area, at the Nursing Station near the hallway next to the dining room, in the hallway in front of an identified resident's room and washrooms of five identified residents' rooms. It was also noted that the shared washroom of two identified rooms,

had a missing ceiling tile over the sink.

On the other resident home area of the same floor, Inspector #626 observed a 12 x12 inches approximate sized cut open area in the ceiling of the dining room, a large area of peeling ceiling plaster in the hallway near Nursing Station and dining room, a large open area approximately 12 x12 inches that was cut out in the ceiling near fire doors next to the activity room, and water marks brownish stains on the ceiling in two resident washrooms of identified residents' rooms.

The other identified floor of the home consisted of two resident home areas.
On one identified resident home area, Inspector #626 observed nine resident washrooms and one resident's room observed with brownish stains on the ceiling tiles in residents’ washrooms of identified rooms.

On the other resident home area on the same floor, Inspector #626 observed seven residents’ washrooms and one resident’s room with brownish/grey stains on the ceiling tiles in residents’ washrooms of identified residents' rooms.

Another identified floor of the home consisted of two resident home areas.
On one identified resident home area, Inspector #626 observed eleven residents’ washrooms with brownish/grey stains on the ceiling tiles in residents’ washrooms of identified residents' rooms.

On the other resident home area on the same floor, Inspector #626 observed ten residents’ washrooms with brownish/grey stains on the ceiling tiles in residents’ washrooms in identified residents' rooms.

In an interview with Inspector #626, resident #040's family member, indicated making a complaint to the Ministry of Health and Long-Term Care regarding the ceiling leak in the home. The family member recognized that the home had been completing repairs over the last two years.

During an interview with Inspector #626, the Administrator indicated being aware of the leakage from the roof and that a drop ceiling was constructed last summer to alleviate the problem. The Administrator also indicated, that the roof is being repaired and a portion was done. In the same interview the Administrator indicated, being uncertain about the cause of the water marks observed in the residents’ washrooms and that it is likely from the toilets. The Administrator also indicated, that the home has started to

change the damaged ceiling tiles in the residents' washrooms. The Administrator indicated, that two companies will be providing the home with estimates to repair the damaged flooring in Spa room.

The licensee had failed to ensure that the home was maintained in a good state of repair. During the initial tour, there were disrepair in terms of water damage to the ceilings in many of the Spa Rooms which contained a shower room, washroom and tub room, located in each of the resident home areas. In another observation, water stains were observed on the washroom ceiling tiles in multiple resident rooms on each of the six resident home areas. These areas of disrepair water leakage in the Spa rooms from the roof and the leakage from the toilet in the residents' rooms to the ceiling below, created a potential risk to the health and wellbeing of residents. [s. 15. (2) (c)]

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 home is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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 had failed to protect residents from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

Neglect is defined in Ontario Regulation 79/10, as "failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being

of one or more residents".

Related to Log #035288-16:

A critical incident report (CIR) was received by the Director on an identified date, for an allegation of staff to resident neglect when resident #030 was not assisted to the dining room for a meal on an identified date.

Resident #030 was admitted to the home on an identified date, with multiple diagnosis including cognitive decline and a condition that affects mobility.

A review of the CIR notes and the licensee's investigation notes revealed that on an identified date, resident #030 did not have their meal until two hours later as the resident was not provided with assistance to the dining room by the assigned PSW #150 or by any other staff.

A review of the written plan of care for resident #030, in effect at time of incident, indicated that resident #030 used an identified mobility aid and could move for short distance; the resident moves with extensive assistance from location to location.

A review of a progress note entry dated six days prior to the incident, restorative care RPN #154 documented that resident #030 preferred staff to assist them with locomotion.

A review of an interview statement with resident #030 dated four days after the incident, revealed the resident indicated to the DOC, that day, they could not make it themselves to the dining room and that they were hungry but nobody assisted them in. The resident further indicated that when they were not ready and prepared for their meal, PSW #150 would become unhappy and shout.

A review of the interview statements of staff who were present and witnessed the incident, revealed that RPN #151, private care giver #155, activity aide staff #146 and PSW #115 all indicated that PSW #150 prevented them from assisting resident #030 to the dining room, indicating the physiotherapist stated the resident needed to exercise.

During an interview, PSW #100 confirmed to Inspector #570 that resident #030 required staff assistance to the dining room for meals. The PSW indicated that they were unaware the resident did not have their meal until two hours later on the date of the incident.

During separate interviews with PSW #115 and activity aide staff #146, both indicated that PSW #150 prevented them from assisting resident #030 to the dining room and were told by PSW #150 the resident should do it on their own.

During an interview, the DOC indicated to Inspector #570 that the investigation was concluded and it was determined that resident #030 was neglected by PSW #150 when the PSW prohibited the resident from having their meal on time.

The licensee had failed to ensure that resident #030 was not neglected by staff when the resident was not assisted by staff to the dining room for two hours. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: 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 had failed to ensure that every allegation abuse, involving resident #036, was immediately investigated.

Related to Log #035305-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified, related to an allegation of staff to resident abuse. The CIR indicated that during an identified meal on an identified date, resident #032 reported that PSW #140 was observed to act inappropriately toward resident #036. The CIR further indicated that on an identified date, resident #036's family member complained to RPN #156 that resident #032 had reported the incident to them. RPN #156 reported the allegation and complaint to the RN Supervisor, and documented the allegation in the 24 hour shift report and resident #036's progress notes.

On an identified date, RN Supervisor #157 read about the allegation in report, and initiated the investigation by following up with resident #032. Resident #032 reiterated the allegation, that PSW #140 acted inappropriately toward resident #036 during an identified meal. No staff were spoken to by RN Supervisor #157.

On an identified date, the DOC received a report related to the allegation which was brought forward two days prior, and continued the investigation at that time.

During an interview on March 21, 2018, the DOC indicated that the expectation in the home was that the RN Supervisor would immediately initiate an investigation, if an allegation of resident abuse was brought forward, and the management team were not in the home. The DOC further indicated during that time, the Registered Staff in the home were struggling with their understanding of the prevention of abuse and neglect policy, therefore re-education on the expectations following receipt of an allegation of resident abuse or neglect was conducted, and staff were reminded to immediately report and initiate an investigation.

The licensee had failed to ensure that the allegation of staff to resident abuse involving resident #036 was immediately investigated, after it was reported on an identified date. [s. 23. (1) (a)]

2. The licensee had failed to ensure that every allegation of staff to resident abuse,

involving resident #029, was immediately investigated.

Related to Log #010523-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to an allegation of staff to resident abuse. The CIR alleged that on an identified date, resident #029's SDM noted resident #029's identified body part was noted to have a change of condition, and resident #029 indicated it was caused by PSW #159. Resident #029's SDM immediately reported this allegation to RPN #160, on an identified date. RPN #160 assessed resident #029's affected body part, and noted the change. Resident #029 informed RPN #160 that their injury was caused, intentionally by PSW #159. Pain medication was given, with good effect. RPN #160 did not report the allegations brought forward on two identified dates, by resident #029's family member and SDM.

A review of resident #029's progress notes revealed that resident #029 started to complain of pain, and a change was noted to the affected area on an identified date prior to reporting the allegation.

During an interview, the DOC indicated that the allegation was not investigated until resident #029's SDM contacted the DOC on an identified date. The DOC further indicated that the expectation in the home was that the RPN would report all allegations brought forward to the RN Supervisor, then the RN Supervisor would immediately initiate an investigation, if the management team were not in the home at the time that the allegation was brought forward. The DOC further indicated at that time, Registered Staff in the home were struggling with their understanding of the prevention of abuse and neglect policy, therefore re-education on the expectations following receipt of an allegation of resident abuse or neglect was conducted, and staff were reminded to immediately report and initiate an investigation.

The licensee had failed to ensure that the allegation of staff to resident abuse involving resident #029 was immediately investigated, after it was initially reported on an identified date. [s. 23. (1) (a)]

3. The licensee had failed to ensure that an allegation of staff to resident abuse, involving resident #029, was immediately investigated.

Related to Log #030024-16:

On an identified date, resident #029's SDM contacted the INFOLine with the MOHLTC, to report allegations of staff to resident abuse, directed towards resident #029, which the SDM felt was retaliation as a result of an allegation submitted earlier an earlier identified date, which alleged staff to resident abuse by PSW #159, towards resident #029. Resident #029's SDM alleged that following the incident on an earlier identified date, SDM had requested to the DOC that PSW #159 no longer be assigned to provide care to resident #029. On an identified date, SDM stated that the change to resident #029's assignment still had not been completed, that PSW #159 continued to be assigned to resident #029, and as a result, PSW #159 was making negative comments to resident #029.

During an interview, resident #029's SDM indicated that following the allegation of staff to resident abuse involving PSW #159 on an identified date, a request had been made to the DOC that PSW #159 no longer provide care to resident #029. Resident #029's SDM further indicated the DOC had informed them that the request would be very difficult to implement, due to other scheduling concerns in the home, and resident #029's SDM felt that the schedule was more important than the resident's or family member's feelings and requests. Resident #029's SDM indicated that due to PSW #159 not being removed from resident #029's assignment following the allegation of identified abuse, resident #029 was subjected to retaliation from PSW #159, which included identified abuse, and that the allegations of abuse had been reported to the DOC.

During an interview, the DOC indicated that they were aware of the allegations from resident #029's SDM, related to staff to resident abuse, involving resident #029 and PSW #159. The DOC further indicated that ADOC #152 had been assigned to deal with the allegation, therefore they were unsure what was the outcome of the internal investigation, and they were aware of the legislative requirements which outlined that every allegation of resident abuse or neglect must be immediately investigated.

During an interview, ADOC #152 indicated that they were aware of the allegation of staff to resident abuse, involving resident #029 and PSW #159, and that following resident #029's SDM bringing forward the allegation, PSW #159 was removed from resident #029's assignment. ADOC #152 further indicated that a formal investigation into the allegation had not been completed, as they had spoken to PSW #159 following to allegation being brought forward, and felt that removing PSW #159 from resident #029's assignment was all that was required to satisfy everyone involved. ADOC #152 indicated being aware of the legislative requirements which outlined that every allegation of

resident abuse or neglect must be immediately investigated.

The licensee had failed to ensure that an allegation of staff to resident abuse, brought forward by resident #029's SDM, was immediately investigated. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 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.

Related to Log #009693-16:

A critical incident report (CIR) was submitted on an identified date, for an allegation of staff to resident abuse that occurred on an identified date five days prior. The CIR indicated, on an identified date, resident #028 reported to PSW #139 while pointing to PSW #140 that "PSW #140 had acted inappropriately toward them.

Review of the CIR notes and the licensee's investigation revealed that the incident was reported to the DOC on an identified date and time.

During an interview, the Director of Care (DOC) indicated to Inspector #570 that ADOC #152 could not report the allegation to the MOHLTC using the after hours number and that a CIR was not submitted that day. The DOC, further indicated, that no other attempts were made to notify the MOHLTC of the allegation until the CIR was submitted on an identified date, five days following the the incident was reported.

The Director was not notified of the allegation of staff to resident abuse until the CIR was submitted five days after the licensee became aware of the allegation. [s. 24. (1)]

2. Related to Log #035288-16

A critical incident report (CIR) was received by the Director on an identified date, for an allegation of staff to resident neglect when resident #030 was not assisted to the dining room for a specified meal on an identified date. Resident #030 was waiting in hallway and was not provided with their meal until two hours later when Activity Aide #146 reported to RN #113 that the resident was not assisted to the dining room and was not provided with their meal.

Review of the CIR notes and the licensee's investigation revealed that RN #113 was aware of the allegation of staff to resident neglect on an identified date. The incident was not reported to the Director until, two days later, when RN #113 reported the incident to the Director of Care (DOC).

During an interview, RN #113 indicated to Inspector #570 that the incident occurred on an identified date when resident #030 was not assisted to the dining and was not provided with their meal was considered neglect. The RN further indicated that they did not immediately report the incident the MOHLTC and that they did not notify the on call

manager of the incident.

During an interview, the DOC indicated to Inspector #570 that the MOHLTC was notified of the incident two days after the incident occurred, and that RN #113, who was in the nursing supervisor and in charge of the home, should have reported the incident immediately on same date it had occurred and should have called the manager on call for direction.

The Director was not notified of the allegation of staff to resident neglect until the CIR was submitted on an identified, two days after the incident was reported to RN #113. [s. 24. (1)]

3. Related to Log #035305-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to an allegation of staff to resident abuse, which occurred three days prior. The CIR indicated that during a meal service on an identified date, resident #032 reported that PSW #140 was observed act inappropriately toward resident #036. The CIR further indicated that on an identified date, resident #036's SDM complained to RPN #156 that resident #032 had reported the incident to them. RPN #156 reported the allegation to the RN Supervisor, and documented the allegation in the 24 hour shift report and resident #036's progress notes. Neither the RPN nor the RN notified the management team of the allegation, nor reported the allegation to the Director.

On an identified date, RN Supervisor #157 became aware of the allegation, after reading of it in the shift report. RN Supervisor #157 did not notify the management team of the allegation, nor report the allegation to the Director.

On an identified date, the DOC received a report related to the allegation which was brought forward on an identified date, two days prior. The DOC notified the Director by submitting the CIR.

During an interview on March 21, 2018, the DOC indicated that the expectation in the home was that the RN Supervisor would immediately notify the management team and the Director, if an allegation of resident abuse was brought forward. The DOC further indicated that during the time of the incident, Registered Staff in the home were struggling with their understanding of the prevention of abuse and neglect policy, therefore re-education on the expectations following receipt of an allegation of resident

abuse or neglect was conducted, and staff were reminded to immediately report all allegations brought forward. The DOC further indicated they were aware of the legislative requirements, which indicated the Director was to be immediately notified of all allegations of resident abuse and neglect.

The licensee had failed to ensure that the Director was immediately notified of the allegation of staff to resident abuse, as the allegation was brought forward on an identified date, and the Director was not notified until two days later. [s. 24. (1)]

4. Related to Log#010523-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to an allegation of staff to resident abuse, which was stated to have occurred on an identified date, one day prior. The CIR alleged that on an identified date, resident #029's SDM noted resident #029's body part was noted to have a change in condition, and resident #029 indicated it was caused by PSW #159. Resident #029's SDM immediately reported this allegation to RPN #160. The CIR further indicated that when resident #029's family member was visiting on an identified date, two days prior, the change in condition was also noted at that time, and resident #029 made the same allegation. Resident #029's family member reported the allegation to the RPN. RPN #160 assessed resident #029's affected body part, and noted the change in condition. Resident #029 informed RPN #160 that their injury was caused on the day prior, intentionally by PSW #159. PRN medications were given, with good effect. RPN #160 did not report the allegation brought forward on same date, by resident #029's family member, nor the allegation brought forward two days later, by resident #029's SDM.

A review of resident #029's progress notes revealed that resident #029 started to complain of pain to the affected body part, and that the change in condition was first noted on an identified date.

Resident #029's SDM contacted the DOC on an identified date and time, three days after the allegation was reported to Registered staff, to inform the DOC of the allegation. The DOC notified the Director on same date.

During an interview, the DOC indicated that the expectation in the home was that all allegations of resident abuse and neglect were immediately reported to the manager on call, and to the Director. The DOC further indicated that during the time of the incident, Registered Staff in the home were struggling with their understanding of the prevention of

abuse and neglect policy, therefore re-education on the expectations following receipt of an allegation of resident abuse or neglect was conducted, and staff were reminded to immediately report all allegations of resident abuse and/or neglect, and to initiate an investigation.

The licensee had failed to ensure that the Director was immediately notified of an allegation of staff to resident abuse involving resident #029, as the allegation was initially brought forward on an identified date, and the Director was not notified until three days after. [s. 24. (1)]

5. Related to Log #030024-16:

On an identified date, resident #029's SDM contacted the INFOLine with the MOHLTC, to report allegations of staff to resident abuse, directed towards resident #029, which the SDM felt was retaliation as a result of a CIR submitted on an earlier identified date, which alleged staff to resident abuse from PSW #159, towards resident #029. Resident #029's SDM alleged that following the incident of abuse on an earlier date, SDM had requested to the DOC that PSW #159 no longer be assigned to provide care to resident #029. On an identified date, resident #029's SDM stated that the change to resident #029's assignment still had not been completed, that PSW #159 continued to be assigned to resident #029, and as a result, PSW #159 acted inappropriately toward resident #029.

During an interview, resident #029's SDM indicated that following the allegation of staff to resident abuse involving PSW #159 on an earlier identified date, SDM had made a request to the DOC that PSW #159 no longer provide care to resident #029. Resident #029's SDM further indicated the DOC had informed SDM that the request would be very difficult to implement, due to other scheduling concerns in the home, and resident #029's SDM felt that the schedule was more important than the residents or family member's feelings and requests. Resident #029's SDM indicated that due to PSW #159 not being removed from resident #029's assignment following the allegation of abuse on an earlier identified date, resident #029 was subjected to retaliation from PSW #159, which included an identified abuse, and that the allegations of abuse had been reported to the DOC.

During an interview, the DOC indicated that they aware of the allegations from resident #029's SDM, related to staff to resident abuse, involving resident #029 and PSW #159. The DOC further indicated that ADOC #152 had been assigned to deal with the allegation, therefore they were unsure whether a CIR had been submitted to the Director

regarding this allegation. The DOC indicated being aware of the legislative requirements which outlined that every allegation of resident abuse or neglect must be immediately reported to the Director.

During an interview, ADOC #152 indicated that they were aware of the allegation of staff to resident abuse, involving resident #029 and PSW #159, and that following resident #029's SDM bringing forward the allegation, PSW #159 was removed from resident #029's assignment. ADOC #152 further indicated that the allegation of staff to resident abuse had not been reported to the Director, but was aware of the legislative requirements which outlined that every allegation of resident abuse or neglect must be immediately reported to the Director.

The licensee had failed to ensure that the allegation of PSW #159 abusing resident #029 through name calling, was reported to the Director, when it was reported to the management team by resident #029's SDM on an identified date. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

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 had failed to 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; (b) and is reported to the resident, the resident's substitute decision-maker (SDM), resident's attending physician or the registered nurse in the extended class.

The licensee's Medication Incident and Reporting policy RC-16-01-09, last updated in February 2017, directed the following:
Required Documents
Progress Notes - used to document all actions related to the resident. Progress notes should have a factual account of what happened and what was done in relation to the medication incident.

Related to resident #004:

In a review of a Medication Incident -Final Report with an identified date, indicated that resident #004's two identified medications, both to be administered at bedtime were omitted on that day. In a review of the progress, no evidence was found that the medication incident was documented and that the resident was assessed, and any adverse reaction was noted. The progress note documentation on an identified date, two days after the incident, indicated that the resident's SDM and physician were informed of the incident but the note did not specify, that a medication incident had occurred and if there was any effect on the resident.

In an interview with Inspector #626, RPN #148 who was involved in the incident, indicated that the resident was capable of making care and treatment decisions. The RPN also indicated not being aware, if the resident was informed of the medication incident. RPN #148 in the same interview also indicated, not being aware if the physician was notified of the incident.

During an interview with Inspector #626, the DOC indicated, that the medication incident was discovered on an identified date, and the physician was notified at that time. In the same interview the DOC indicated that the medication incident, resident assessment, adverse reaction, notification of the SDM and physician must be documented in the progress notes and had not been.

The licensee had failed to ensure that the medication incident involving resident #004 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The incident was not documented or reported to the resident's SDM until two days after it had occurred and one day after it was discovered. The resident's attending physician was notified, one day after the incident was discovered.

Related to resident #031:

In a review of a Medication Incident-Final Report with an identified date, indicated that resident #031's identified medication, one tablet twice daily to be administered at identified time was administered twice on the day shift by RPN #149. The incident report indicated that the physician was notified but did not indicate notification of the SDM. The progress note documentation on an identified date, indicated the medication was given in error but did not note that the resident's SDM or physician was informed of the incident, or if the resident was assessed and if there was any effect on the resident. The licensee's Medication Incident and Reporting policy RC-16-01-09 directed the documentation of medication incidents in the home noted in the progress notes.

Resident #031 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

In an interview with Inspector #626, RPN #149 who was involved in the incident, indicated that the resident did not have a designated SDM and was capable of making care and treatment decisions. The RPN indicated informing the resident of the medication incident. The RPN also indicated, not documenting if the resident was assessed, the effect on the resident and the notification of the resident or physician in the progress notes as expected.

Inspector #626 reviewed the resident's health record, and determined that the resident had a designated SDM.

In an interview with Inspector #626, ADOC #158 indicated that it is the expectation that the resident was assessed, effect on the resident noted, the SDM and physician was notified and the information documented in the progress notes.

During an interview with Inspector #626, the DOC indicated that the resident's SDM and physician should have been notified of the medication incident. The DOC also indicated, that the resident was capable of making care and treatment decisions. The resident's SDM would only be notified of incidents such as a fall. There was an email provided by the SDM that gave direction to be contacted, only if the resident had passed away. The DOC indicated, the request of the SDM to be notified only if the resident was deceased was probably provided after this incident. The DOC did not provide evidence of the SDM's request.

The licensee had failed to ensure that the medication incident involving resident #031

was documented, together with a record of the effect on the resident as well as immediate actions taken to assess and maintain the resident's health. The medication incident report did not indicate that the SDM was not informed. There was no documented evidence in the progress notes that the resident's SDM and physician were notified.

Related to resident #032:

In a review of the Medication Incident-Final Report with an identified date, indicated that resident #032's identified seven medications, all scheduled to be administered at an identified time were omitted.

In a review of the progress notes, there was no documented evidence found that the medication incident or the SDM and physician were notified. The licensee's Medication Incident and Reporting policy RC-16-01-09 directed the documentation of medication incidents must be noted in the progress notes.

Resident #032 was admitted to the home on an identified date, with multiple identified diagnoses.

In an interview with Inspector #626, RPN #147 indicated notifying the resident's SDM and physician of the incident but did not document this information in the progress notes. The RPN also indicated not documenting the medication incident or the effect on the resident in the progress notes and should have.

In an interview with Inspector #626, ADOC #158 indicated that the RPN should have documented the medication incident, effect on the resident as well as the physician and SDM notification in the progress notes. The ADOC also indicated that disciplinary action was taken and the RPN reviewed the College of Nurses (CNO) medication standards. Random medication audits being conducted to ensure that medications are not missed.

During an interview with Inspector #626, the DOC indicated that the medication incident, effect on the resident as well as the physician and SDM notification must be documented in the progress notes. In the same interview, the DOC indicated that this information was not documented. The policy is that the documentation must be there to alert the next shift, in order for the resident to be monitored.

The licensee had failed to ensure that the medication incident involving resident #032

was documented. There was no documented evidence of the medication incident and notification of the resident's SDM and physician found in the progress notes.

Related to resident #033:

In a review of the Medication Incident Final Report with an identified date, indicated that resident #033's identified medications. All of the omitted identified medications were to be administered at an identified date and time, with the exception of one identified medication, which was to be given at an earlier time that morning. In a review of the progress notes, there was no documented evidence found of the medication incident or the notification of the SDM and physician. The licensee's Medication Incident and Reporting policy RC-16-01-09 directed the documentation of medication incidents must be noted in the progress notes.

Resident #033 was admitted to the home on an identified date, with multiple diagnoses which included cognitive decline.

In an interview with Inspector #626, RPN #147 indicated that they notified the resident's SDM and physician of the incident. The RPN also indicated they did not document the medication incident or the notification of the resident's SDM and physician in the progress notes as expected.

In an interview with Inspector #626, ADOC #158 indicated that the RPN should have documented the medication incident as well as the physician and SDM notification in the progress notes. The ADOC also indicated, that disciplinary action was taken and the RPN reviewed the College of Nurses (CNO) medication standards. Random medication audits on this staff is being conducted to ensure that medications are not missed.

During an interview with Inspector #626, the DOC indicated that the medication incident, effect on the resident, physician and SDM notification must be documented in the progress notes. In the same interview the DOC indicated, that this information was not documented. The policy is that the documentation must be there to alert the next shift, in order for the resident to be monitored.

The licensee had failed to ensure that the medication incident involving resident #033 was documented. There was no documented evidence that the medication incident, notification of the resident's SDM and physician found in the progress notes.

Related to resident #034:

In a review of the Medication Incident Final Report dated with an identified date, indicated that resident #033's identified medications were omitted. All of the omitted medications were to be administered at an identified date. In a review of the progress notes, there was no evidence found that the medication incident or the notification of the SDM and physician were documented. The licensee's Medication Incident and Reporting policy RC-16-01-09 directed the documentation of medication incidents must be noted in the progress notes.

Resident #034 was admitted to the home on an identified date, with multiple diagnoses which included cognitive decline.

In an interview with Inspector #626, RPN #147 recalled not administering the resident's specified medication but did administer it to the resident at a later hour with the physician direction, after notifying the doctor of the incident. The RPN indicated notifying the resident's SDM. RPN #147 also indicated, not documenting the medication incident or that the resident's SDM and physician were notified in the progress notes as expected.

During an interview with Inspector #626, the DOC indicated that the medication incident, effect on the resident, physician and SDM notification must be documented in the progress notes. In the same interview the DOC indicated, that this information was not documented. The policy is that the documentation must be there to alert the next shift, in order for the resident to be monitored.

The licensee had failed to ensure that the medication incident involving resident #034 was documented. There was no documented evidence that the medication incident as well as the notification of the resident's SDM and physician was noted in the progress notes. [s. 135. (1)]

2. The licensee had failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed and that corrective action was taken as necessary, and a written record was kept.

Related to resident #031:

In a review of the Medication Incident -Final Report with an identified date, indicated that resident #031's identified medication to be administered at two identified times, was

administered twice on the day shift by RPN #149. A review of the Medication Incident Report and the progress notes did not indicate, that the medication incident was reviewed and analyzed or that corrective action was taken in regards to the incident. The Medication Incident Report indicated that RPN #149 was disciplined in relation to the incident but no evidence was found to substantiate this claim.

Resident #031 was admitted to the home on an identified date, with multiple diagnoses which included cognitive decline.

In an interview with Inspector #626, RPN #149 indicated, that incident was reported to ADOC #158 but it was not reviewed with the RPN. The RPN also indicated that no disciplinary action was taken in regards to the medication incident as noted in the Medication Incident -Final Report .

During an interview with Inspector #626, ADOC #158 indicated not being aware of any investigation pertaining to the medication incident. The ADOC also indicated, not being aware of any corrective action being taken in regards to the incident.

During another interview with Inspector #626, the DOC indicated not being aware of any investigation into the medication incident and of any corrective action being taken.

In an interview, the DOC indicated that medication incidents must be investigated and reviewed at the time when the incident occurred. The analysis happens during the Medication Management meeting which is held quarterly, to determine how to prevent recurrences. This information should be included in the incident report and the quarterly review.

The licensee had failed to ensure that, the medication incident and any adverse drug reactions were documented including the review, analysis as well as the corrective action taken and a written record was kept, in relation to the medication incident involving resident #031. [s. 135. (2)]

3. The licensee had failed to ensure that, a quarterly review was 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. The quarterly review must indicate, if any changes and improvements identified in the review were implemented, and a written record was kept.

A review of the home’s Profession Advisory Committee (PAC) meeting minutes from identified quarter, identified that there were five medication incidents documented involving dispensing, omissions and a wrong dose. There was no identification of the most prevalent type of errors as well as the changes and improvements that were implemented were not documented.

In an interview with Inspector #626 on March 20, 2018, the DOC indicated they were responsible of reviewing the medication incidents. In another interview, the DOC indicated that medication incidents must be reviewed when the incident occurs. The analysis happens during the Medication Management meeting, which is held quarterly and is used to determine how to prevent further incidents. This information was to be included in the incident report and the quarterly review.

The licensee had failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review, included any changes and improvements that were implemented, and that a written record was kept. There was no documented evidence in the Medication Management meeting minutes of an identified period that the prevalence of the medication incidents, pertained to the omission of medications and that a discussion took place pertaining to changes that were implemented for prevention. [s. 135. (3)]

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 medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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;
to ensure all medication incidents and adverse drug reactions are documented, reviewed and analyzed and that corrective action is taken as necessary, and there is a written record is kept of everything required; and 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, any changes and improvements identified in the review are implemented, and a written record is kept of everything provided, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee had failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The servery doors to an identified residents' home areas and the Laundry Chute room are located in an identified hallway area. There is no door to restrict residents from entering this hallway.

During the initial tour of the building, Inspector #626 observed that an identified Laundry Chute outside an identified residents' home area, was locked but the key was left in the lock. There were no staff visible in this area. In a nearby area, fourteen residents were involved in an activity. A hook secured at shoulder height was noted on the wall beside the door, where PSWs #115 and #104 indicated that the key was usually kept. The lock was changed, to a coded entry lock.

In an interview with Inspector #626, PSWs #115 and #104, both indicated that the door to the Laundry Chute must be kept locked and the key is stored on the hook beside the door. PSW #115 also indicated that a dietary staff had left the key in the lock in the door to the Laundry Chute room.

During an interview with Inspector #626, the Administrator indicated that the key should not have been left in the lock of the Laundry Chute room door.

In the same hallway on March 5, 2018, the door to the identified servery room was found opened and a wooden wedge was used to keep it from closing. There was no staff initially present in the area. The food warming table in the servery was turned on, contained warm water and steam was visible. The door to the servery area in an identified residents' home area dining room was opened and there was one resident in a wheelchair asleep in the dining room. On March 7, 2018, the door was observed to be opened but a dietary staff was in the servery. On March 8, 2018, the servery door was found closed but not locked and the dining room door was also opened. During the same observation, Dietary Aide #127 entered the servery and indicated that a key was not available to lock the door. On March 9, 2018, the door to the servery was closed but not locked, the food warming table contained hot water and was steaming. There were no staff in the area initially and Dietary Aide #145 who came into the area and indicated that the lock on the door to the servery was broken and could not be locked. On March 13, 2018, the door was observed to be closed and locked.

In an interview with Inspector #626, PSWs #115 and #104, both indicated that the door to the servery should have been locked.

During an interview with Inspector #626, Dietary Aide #128 indicated that the door to the

servery should have been kept locked.

In another interview, Dietary Aide #127 was not aware that the door should have been kept locked and that a key was not available to lock the door.

During an interview with Inspector #626, the Administrator, indicated that the door to the servery should be kept locked. In another interview, the Administrator indicated that the door to servery, should be kept locked and that a key will be provided to the dietary staff.

In an interview, Dietary Aide #145 indicated that the servery door, room #1102 cannot be locked as the lock was broken and would be repaired that day.

The licensee had failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access by residents, and that those doors were kept closed and locked. [s. 9. (1) 2.]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the use of a PASD under subsection (3) to assist the resident with a routine activity of living was included in the resident's plan of care only if all of the following are satisfied:
The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

Related to resident #005:

During stage one of the RQI, the use of a mobility device with reclining feature by resident #005 was triggered as a potential restraint.

Resident #005 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

During multiple observations, Inspector #626 observed resident #005 using an identified device, which was in the reclining position.

A review of the resident's medical records, did not indicate that resident #005's identified device was placed in the reclining position as an intervention and being used as a PASD. There was also no documentation found to indicate, that the use of the identified device as a PASD was approved by a physician, registered nurse, registered practical nurse or any other person provided for in the regulations.

In an interview with Inspector #626, PSW #129 indicated that the identified device was used as a PASD for resident #005. The PSW also indicated, that resident #005 has the tendency of leaning forward while using the identified device and would slide out of the device, if not placed in the reclining position.

In another interview with Inspector #626, PSW #125 indicated that the identified device was used as a PASD for resident #005, as it prevented the resident from falling forward.

In an interview with Inspector #626, RPN #130 indicated that the identified device was used as a PASD for resident #005 and that there was no physician order or nursing approval documented in the resident's health records.

During an interview with Inspector #626, the DOC indicated that there was no approval found for the use of the identified device as a PASD. The DOC also indicated, that there should have been an order from the physician or nurse for the use of the identified device as a PASD.

The licensee had failed to ensure that the use of the PASD to assist resident #005 with a routine activity of living was ordered by a physician, approved by a registered nurse, registered practical nurse or any other person provided for in the regulations. [s. 33. (4) 3.]

2. The licensee had failed to ensure that the use of the PASD had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Related to resident #005:

During stage one of the RQI, the use mobility device with reclining feature by resident #005 was triggered as a potential restraint.

Resident #005 was admitted to the home on an identified date, with diagnoses which included cognitive decline.

A review of the resident's medical records, did not indicate that resident #005's identified device was placed in the reclining position as an intervention and being used as a PASD. There was also no documentation found to indicate, that a consent was provided by the SDM for the use of the identified device in the reclining position as a PASD.

In an interview with Inspector #626, PSW #129 indicated that the identified device was used as a PASD for resident #005. The PSW also indicated, that resident #005 had the tendency of leaning forward while using the identified device and would slide out of the device, if not placed in the reclining position.

In another interview with Inspector #626, PSW #125 indicated that the identified device was used as a PASD for resident #005, as it prevented the resident from falling forward.

In an interview with Inspector #626, RPN #130 indicated that the identified device was used as a PASD for resident #005.

The RPN also indicated, that there was no documentation found in the resident 005's health records that a consent was provided by the SDM, for the use of the identified device.

During an interview with Inspector #626, the DOC indicated that the identified device in the reclining position is a PASD and there should have been a documented consent for the use of the PASD. The DOC also indicated that the resident's SDM was aware of the use of the identified device.

The licensee had failed to ensure that the PASD had been consented to by resident #005's SDM. Resident #005 was observed in an identified device, in the reclining position which was being used as a PASD, there was no documented evidence found that the SDM had provided consent. [s. 33. (4) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the designated lead for housekeeping, laundry, and maintenance had a post-secondary degree or diploma.

During inspection of the maintenance processes in the home it was identified that the Maintenance Supervisor's education did not meet the legislative requirements. In an interview with Inspector #626, the Maintenance Supervisor #101 of the home indicated employed by the home for the past eight years. The Maintenance Supervisor indicated that they were responsible for the Maintenance program in the home. The Maintenance Supervisor also indicated that they had a high school education and did not have a post-secondary degree or diploma but had attended yearly seminars pertaining to maintenance.

During an interview with Inspector #626, the Administrator indicated that the Maintenance Supervisor is a contract employee from an identified company. In another interview on March 20, 2018, the Administrator indicated that, the Maintenance Supervisor was grandfathered and did not have the required education for the position. The Administrator indicated, that the Maintenance Supervisor is responsible for the Maintenance program in the home and is also responsible for a part-time maintenance worker. The Administrator also indicated, that the contract company will be financing the upgrade of the Maintenance Supervisor's education in order to meet compliance.

The licensee had failed to ensure that the designated lead for maintenance have a post-secondary degree or diploma and does not meet the legislative requirements to be grandfathered. [s. 92. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure the resident's Substitute Decision Maker (SDM) and any other person specified by the resident, were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to Log #009693-16:

A critical incident report (CIR) was submitted on an identified date, for an allegation of staff to resident abuse. The CIR indicated, on an identified date, resident #028 reported to PSW #139 while pointing to PSW #140 that PSW #140 had acted inappropriately toward them.

During an interview, the Director of Care (DOC) indicated to Inspector #570 that they became aware of the incident on an identified date, and that the incident was investigated by ADOC #152. The DOC further indicated that the SDM of resident #028 was notified of the allegation on an identified date, one day later.

The SDM of resident #028 was not immediately notified of the allegation of staff to resident abuse until one day after the incident was reported to the DOC. [s. 97. (1) (a)]

2. The licensee had failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other

alleged, suspected or witnessed incident of abuse or neglect of the resident.

Related to Log #035288-16

A critical incident report (CIR) was received by the Director on an identified date, for an allegation of staff to resident neglect when resident #030 was not assisted to the dining room for a specified meal on an identified date. Resident #030 was waiting in hallway and was not provided with their meal until two hours when Activity Aide #146 reported to RN #113 that the resident was not assisted to the dining room and was not provided with their meal.

Review of the CIR notes and the licensee's investigation revealed that RN Supervisor #113 was aware of the allegation of staff to resident neglect on an identified date.

During an interview, RN #113 indicated to Inspector #570 that the incident occurred on an identified date, when resident #030 was not assisted to the dining room and was not provided a specified meal is considered neglect. The RN further indicated that they did not notify the SDM of resident #030 of the incident.

During an interview, the Director of Care (DOC) indicated to Inspector #570 that the SDM of resident #030 was notified of the allegation on an identified date, two days after the incident when the incident was reported to them by RN #113.

The SDM of resident #030 was not notified within 12 hours upon becoming aware of any the alleged incident of neglect of the resident. [s. 97. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that all written complaints relating to a matter that the licensee reported to the Director under section 24 of the Act, and the corresponding written report documenting the response the licensee made to the complainant was forwarded to the Director.

Related to Log #035305-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, related to an allegation of staff to resident abuse. The CIR indicated that during a specified meal on an identified date, resident #032 reported that PSW #140 was observed to act inappropriately toward resident #036. The CIR further indicated that on an identified date, resident #036's SDM complained to RPN #156 that resident #032 had reported the incident to them, and on an identified date following the incident, resident #036's SDM hand delivered a formal letter of complaint related to the allegation of staff abuse, to the DOC and Administrator.

Inspector #672 reviewed the internal complaints log for an identified year, and did not locate the written complaint from resident #036's SDM, the written response from the home regarding the complaint, nor the documentation which supported that the complaint was forwarded to the Director.

During a telephone interview, resident #036's SDM indicated that a written complaint had been submitted to the home on an identified date, but a written response from the management team in the home related to the complaint was never received.

During an interview, the DOC indicated that they could not recall if the written complaint received had been added to the internal complaints log. The DOC further indicated that they did not believe the written complaint had been forwarded to the Director, because a CIR had been submitted which outlined the allegation, and they believed that could serve as notification to the Director. The DOC indicated that perhaps the written complaint had been submitted by the Administrator, as the Administrator was responsible for the management of the internal complaints log, and was aware of the legislation which required all written complaints received by a LTC home, along with the written responses to the complainant, to be forwarded to the Director.

During an interview, the Administrator indicated that all written complaints were

maintained within the same complaints log, but could not locate the written complaint from resident #036's SDM, the written response to the complainant, or documentation that the written complaint had been forwarded to the Director, within the internal complaints log. The Administrator further indicated being aware of the legislation which required all written complaints received by a LTC home, along with the written responses to the complainant be forwarded to the Director, but could not recall forwarding this written complaint to the Director.

The licensee had failed to ensure that the written complaint received from resident #036's SDM, related to an allegation of staff to resident abuse, along with a copy of the written response to the complainant, was forwarded to the Director. [s. 103. (1)]

WN #14: 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 :

1. The licensee had 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 #009693-16:

A critical incident report (CIR) was submitted on an identified date, for an allegation of staff to resident abuse. The CIR indicated, on an identified date, resident #028 reported to PSW #139 while pointing to PSW #140 that PSW #140 had acted inappropriately toward them.

Review of the licensee's investigation notes and interview with the Director of Care (DOC) indicated that PSW #124 had also been interviewed related to the allegation as PSW #124 was present at the time of the incident on an identified date.

The name of PSW #124, who was present at the time of the incident and interviewed related to the allegation, was not identified in the CIR. [s. 104. (1) 2.]

2. Related to Log #035288-16

A critical incident report (CIR) was received by the Director on an identified date, for an allegation of staff to resident neglect when resident #030 was not assisted to the dining room for a specified meal on an identified date. Resident #030 was waiting in the hallway and was not provided with their meal until two hours later when activity aide #146 reported to RN #113 that the resident was not assisted to the dining room and was not provided with their meal.

A review of the licensee's investigation notes and interview with the Director of Care (DOC) indicated that interviews were conducted with RPN #151, private care giver #155, activity aide #146, PSW #115 and PSW #100 in relation to the incident of alleged neglect as staff identified were present at the time of the incident.

The names of RPN #151, private care giver #155, activity aide staff #146, PSW #115 and PSW #100, who were present at the time of the incident and interviewed related to the allegation of neglect of a resident, were not identified in the CIR. [s. 104. (1) 2.]

3. The licensee had 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 #009693-16:

A critical incident report (CIR) was submitted on an identified, for an allegation of staff to resident abuse that occurred on an identified date and time. The CIR Indicated, on an identified date, resident #028 reported to PSW #139 while pointing to PSW #140 that PSW #140 had acted inappropriately toward them. The final report to the Director was not submitted to indicate the outcome of the licensee's investigation.

During an interview, the Director of Care (DOC) indicated to Inspector #570 that the allegation of abuse was unfounded and that a final report to the Director was not submitted to indicate the outcome of investigation. [s. 104. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).

Findings/Faits saillants :

1. The licensee had failed to inform the Director upon becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out a description of the incident, the names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded to the incident.

Related to Intake Log #019951-16:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, which involved resident #037 being sent to the hospital as a result of a change in condition related to medication incident when resident #037's medications were not administered in a specified shift. The CIR did not contain a list of the omitted medications and did not list all the names of the staff involved in the incident.

Resident #037 was admitted to the home on an identified date, with multiple identified diagnoses which included cognitive decline.

A review of the home's Medication Incident Report with specified date, indicated that resident #037's identified medications, all to be administered at specified time were omitted. The name of RPN # 161, who was involved in omitting the resident's medications and the list of omitted medications were not noted in the CIR.

During an interview with Inspector #626, the DOC indicated completing the CIR and had forgotten to include the names of the medications, and of the staff who was involved in the medication incident. In the same interview the DOC also indicated, not amending the CIR to include the missing information.

The licensee had failed to inform the Director upon becoming aware of the incident in making a report in writing setting out a description of the incident including the names of any staff members or other persons involved with the incident. The list of omitted medication and the name of RPN #161, who was involved in the incident were not noted in the CIR. [s. 107. (4) 2.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A review of the Medication Annual Evaluation form dated March 14, 2018, did not indicate that that the Registered Dietitian (RD) was involved in the annual review.

During an interview with Inspector #672, RD #144 indicated, not attending the annual medication review meetings, as it is held when they are usually not in the home. The RD #144 also indicated, attending the Professional Advisory Committee meeting where medications were discussed but did not attend the Medication Annual Evaluation meetings.

In an interview with inspector #626, the DOC indicated that the Registered Dietitian was not involved in annual review of medications in the home.

The licensee had failed to ensure that an interdisciplinary team, which meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, included the Registered Dietitian. [s. 116. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that, drugs are stored in an area or a medication cart that is secure and locked.

During the initial tour of the building on an identified residents' home area, Inspector #626 observed an identified medication bottle on the top of the medication cart which was located in the nursing station. The medication cart was locked. At the time of the observation there were five residents sitting in the lounge area which is directly in front of the nursing station. There were no registered staff in the immediate area at the time of the observation. The access door to nursing station door lock was broken preventing the door from locking.

In an interview with Inspector #626, RPN #102, indicated that the medication should not have been left on top of the medication cart.

During an interview with Inspector #626, the Administrator indication that the medication should not have been left on top of the medication cart.

In an interview with Inspector #626, the DOC indicated that the medication should not have been left on top of the medication cart.

The licensee had failed to ensure that, drugs were stored in an area or a medication cart that was secure and locked. [s. 129. (1) (a)]

WN #18: 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 had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Related to Log #024209-16:

Resident #027 was admitted to the home on an identified date, with medical diagnosis which included a conditions that affected mobility and swallowing.

Resident #027 was not cognitively impaired and as a result of the medical conditions, resident #027 was at a nutritional risk.

A review of resident #027's three months' Physician's Order Audit Report, indicated that resident #027 was ordered to receive an identified medication prior to meals, to assist with the eating process, and decrease the nutritional risk.

Inspector #672 reviewed the progress notes for resident #027 for an identified period of three months, and observed several notations where complaints were made by resident #027, or the resident's family members that the identified medication was not given on time, which caused difficulty with safely enjoying the meal served.

During an interview, the RD indicated that resident #027 would frequently complain that they either had not received the identified medication, or did not receive the medication on time, when attempting to enjoy a meal.

During an interview, the DOC indicated they were aware that there had been previous concerns with resident #027 receiving the identified medication prior to meals. The DOC further indicated, following a medication audit, they followed up with one Registered Staff member related to resident #027 not receiving the identified medication, after resident #027's family member brought forward a complaint. The DOC indicated that the expectation in the home was that all medications were administered to residents in accordance with the directions specified by the prescriber.

Inspector #672 reviewed the Physician's Audit Report for an identified period of four months, which revealed the times the medications were signed as being administered to the resident, and made the following observations:

In an identified month, there were 21 instances where the identified medication was signed for as administered after the beginning of the breakfast meal, and 22 instances where the medication was signed for as administered after the beginning of the lunch meal.

In the following month, there were 20 instances where the identified medication was signed for as administered after the beginning of the breakfast meal, and 25 instances where the medication was signed for as administered after the beginning of the lunch meal.

In the following month, there were 19 instances where the identified medication was signed for as administered after the beginning of the breakfast meal, and 14 instances where the medication was signed for as administered after the beginning of the lunch meal.

In the following month, there were 21 instances where the identified medication was signed for as administered after the beginning of the breakfast meal, and 21 instances where the medication was signed for as administered after the beginning of the lunch meal.

The licensee had failed to ensure that resident #027 received the identified medication according to the directions as specified by the prescriber. [s. 131. (2)]

Issued on this 22nd day of August, 2018

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

Original report signed by the inspector.