Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 08, 2017;	2017_639607_0013 (A2)	005944-17	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East WHITBY ON L1N 6A3

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

FAIRVIEW LODGE
632 DUNDAS STREET WEST P.O. BOX 300 WHITBY ON L1N 5S3

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

Ontario

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

JULIET MANDERSON-GRAY (607) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an amendment to compliance date

Issued on this 8 day of September 2017 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

JULIET MANDERSON-GRAY (607) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 12, 13, 14, 15, 16, 19, 22, 23, 26, 27, 28 and 29, 2017

During this Resident Quality Inspection, the following intakes were inspected:

Log`s # 008733-17, 026615-16, 026684-16, 028510-16, 028565-16, 028928-16, 030344-16, 031647-16, 032032-16, 032429-16, 032758-16, 032766-16, 032817-16, 033270-16, 002340-17, 002779-17, 005698-17, 006134-17 and 035319-16.

Summary of Intakes:

1) Log #'s 008733-17 and 035319-16: Complaints regarding resident care areas.

2) Log #'s 033270-16, and 005698-17: Regarding alleged staff to resident's abuse.

3) Log #'s 026684-16, 028928, 028510-16, 032817-16: Regarding residents to residents abuse that resulted in harm to the residents.

4) Log #'s 026615-16, 031647-16, 032429-16, 032758-16, 032766-16: Regarding falls that resulted in injuries for which residents were taken to hospital.

5) Log #'s 028565-16, 030344-16, 032032-16, 002340-17: Regarding missing or unaccounted for control substances.

6) Log # 006134-17: Regarding an incident that resulted an injury for which a resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Medical Director (MD), Administrator, the Director of Care (DOC), Manager of Nursing Practice (MNP), Nurse Practitioner (NP), Physiotherapists (PT), Occupational Therapist (OT) , Environment Service Supervisor (EVS), Registered Dietitian (RD), Director of Resident Programs, Resident Care Coordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Residents, President and Chair to Resident and Family Council.

During the course of the inspection, the Inspector(s), toured the Long-Term Care home, observed staff to residents interactions, observed resident to resident interactions, reviewed clinical health records, internal investigation notes, reviewed meeting minutes of Resident Council, annual staff retraining records for 2015 and 2016, reviewed home specific policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Falls Prevention

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **13 WN(s)**
- **8 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations and by identifying and implementing interventions.

Related to Log # 028928-16 involving resident #030, #031, #032 and #049:

A Critical Incident Report was submitted to the Director, for an incident of resident to resident abuse involving resident #030. The CIR indicated on an identified date, a visitor reported to Registered Practical Nurse (RPN) #124 that resident #030 was witnessed exhibiting responsive behaviours towards resident #031. The CIR also indicated resident #030 had prior incidents of responsive behaviours towards other residents in the past, and some resulted in injuries.

Review of the written plan of care, in place at the time of incidents, for resident #030 related to responsive behaviours, indicated the resident had several interventions in place.

On an identified date, interview with PSW #134 by Inspector #111, indicated resident #030 wanders around the unit with the use of a mobility aid independently, but does exhibit responsive behaviours towards other residents.

On an identified date, interview with the Behaviour Supports Ontario (BSO) RPN #126 by Inspector #111 indicated the BSO team currently enters the BSO information directly into the resident's Progress Notes which includes the responsive behaviours exhibited, triggers and strategies to manage the behaviours. The RPN indicated they also initiate any behaviour monitoring tools put in place, receive electronic referrals from the registered staff, and further indicated a referral was received after the incident involving resident #030 and #031. The RPN indicated the resident did have prior incidents of resident to resident responsive behaviours, but was not placed in the BSO program until after the incident on an identified date. The RPN indicated resident #030 demonstrated several responsive behaviours towards staff and other residents. The RPN indicated resident #030 was cognitively impaired and indicated the BSO program created a communication device for staff and or resident to use to improve communication of the resident needs. The RPN indicated the resident also had a Dementia Observation System (DOS) implemented for four days after the incident, and further indicated that a

Behavioural Assessment Tool (BAT) was completed. The RPN indicated he/she would then use the BAT to update the resident's written care plan.

Review of the Progress Notes for resident #030, #031, #032 and #049 related to responsive behaviours, indicated there were several incidents over a four month period, involving resident #030. Further review of the health care records for resident #029, #030, #032 and #049 and interview of staff indicated all four residents were cognitively impaired.

A Behavioural Assessment Tool (BAT) and a Physical, Intellectual, Emotional Capabilities, Environmental and Social Culture (PIECES) assessment was completed on an identified date, ten days after the incident that occurred. The PIECES indicated resident #030 was exhibited responsive behaviours towards other residents. The BAT, indicated resident #030 demonstrated responsive behaviours and identified several triggers and interventions.

A Dementia Observation Scale (DOS) was completed, days after the incident had occurred, and indicated the resident had no responsive behaviours during that time period.

The Progress Notes indicated, there were several incidents of resident to resident responsive behaviours and potentially harmful interactions that resident #029 exhibited towards other residents, two resulting in injury. There was no documented evidence that an interdisciplinary assessment was completed to identify factors that could potentially cause the resident's trigger. The altercations and interventions were not identified and or implemented until five to ten days after an identified incident. The interventions were also not implemented after the last incident, and the written plan of care was not updated to reflect the assessment (BAT) completed. [s. 54. (a)]

2. Related to Log #'s 028510-16 and 032817-16 involving resident #029:

Review of the Progress Notes for resident #029 over a four month period, indicated the resident was involved in several incidents of resident to resident responsive behaviours towards three different residents (resident #028, #054, and #055), and on more than one occasion. There were no further documented incidents of responsive behaviours until several months later, when resident #029 began demonstrating responsive behaviours towards other residents (resident #057, #058, #059 & #060).

On an identified date, interview with Personal Support Worker (PSW) #102 by Inspector #111, indicated resident #029 had not had any responsive behaviours until a few weeks prior, when staff started to noticed the resident exhibiting responsive behaviours towards other residents who are cognitively impaired, and further indicated resident #029 had responsive behaviours two weeks prior, with another resident that resulted in injury.

On an identified date, interview with RPN #148 by Inspector #111, indicated after the incident occurred between resident #029 and resident #058, the RPN monitored resident #029 for the remainder of the shift, and indicated he/she probably reported the incident to the Registered Nurse (RN), but could not recall who the RN was.

A review of the written plan of care for resident #029 related to responsive behaviours, in place at time of incidents, indicated resident #029 demonstrated several responsive behaviours, and had several interventions in place. The care plan was updated on two identified dates. A BSO referral was completed on an another identified date, in regards to the resident's responsive behaviours.

A Physical, Intellectual, Emotional Capabilities, Environmental and Social Culture (PIECES) assessment was completed on an identified date. There was no documented evidence to indicate actions had been taken to prevent risk of injury or harm to others.

A Behavioural Assessment Tool (BAT) was completed on an identified date, and this was completed before the escalation of responsive behaviours towards other residents.

On an identified date, interview with the Resident Care Coordinator (RCC) #125 by Inspector #111, indicated the incident had occurred on a weekend and the RCC became aware of it two days later, upon returning to work. The RCC indicated he/she spoke with RPN #148 regarding the note on an identified date, and further indicated, because the incident was not witnessed, it was not reported to the Ministry of Health and Long-Term Care or Police. In addition, RCC #125 indicated he/she would only report suspected incident of abuse if it was a repeated pattern or intent to injure; and further indicated because both residents have cognitive impairments, they decided the incidents were not reportable. The RCC indicated he/she spoke to RPN #148, regarding the incident, and indicated a BSO referral

was not completed, until three days later.

RCC #125 indicated not being aware of the three incidents that occurred on two identified dates over a two month period, involving resident #029. The RCC further indicated he/she was notified of the incident that occurred on an another identified date, by RN #150, as the RN emailed the RCC regarding the incident, and indicated no further action was taken as the BSO team was already involved. The RCC indicated being aware of another incident that occurred on another identified date, because RPN #148 contacted him/her about the incident, but did not take any further action, as again, the BSO team was already involved. The RCC also indicated they discussed closer monitoring, and staff to be aware of whereabouts of resident #029.

On an identified date, interview with the BSO RPN #126 by Inspector #111, indicated resident #028, #029, #053, #054, #055, #056, #057, #058 #059 and #060 were all cognitively impaired and resident #029 was currently being monitored in the BSO program. The RPN further indicated interventions related to resident #029's behaviours were identified in the residents plan of care and was provided to staff, located in a specific area. RPN #126 indicated resident #029 also had a Dementia Observation System (DOS) completed, along with a referral for consultation. The home was unable to provide a copy of the consultation report. Review of the DOS for resident #029 indicated it was completed for five days within a specified period, and the resident was not being monitored every half hour.

On an identified date, interview of RN #133 by Inspector #111, indicated the RN completes the PIECES assessments or BAT tools, and will also start a DOS assessment before completing a referral to the BSO team. The RN indicated they do not always get BSO team involved with residents behaviours, until they can identify the resident's triggers and behaviours and possible strategies first.

On an identified date, interview with RN #153 by Inspector #111, indicated no awareness of being notified of the incidents that occurred on three identified dates, over a two month period, and indicated this would have been documented in resident #029's Progress Notes.

On an identified date, interview with the Director of Care (DOC) by Inspector #111, indicated not being aware of the incidents of resident to resident abuse, between resident #028 and resident #029, and on another identified date, between resident #029 and resident #057, as well as, the incidents of abuse that occurred on six

identified dates over a four month period. Thus, no investigations were completed regarding the incidents.

A Compliance Order was warranted due to the scope and severity of identified incidents. There were several incidents of resident to resident responsive behaviours and potentially harmful interactions involving resident #030 and other residents, two resulting in injury. There was also no documented evidence that an interdisciplinary assessment was completed, and or the information provided to the licensee or staff through observation were completed to identifying factors that could potentially cause the residents trigger. The altercations or interventions involving resident #030 were not identified and implemented until five to ten days after an identified incident. The interventions were also not implemented after the last incident, and the written plan of care was not updated to reflect the assessment (BAT) completed, as well as, there were several incidents of resident to resident responsive behaviours and potentially harmful interactions involving resident #029 and other residents, three resulting in injury. [s. 54. (a)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of restraint, Personal Assistance Service Device (PASD) and a fall prevention device.

Observation of resident #010 on an identified date, indicated the resident was seated in a mobility aid with a restraint in place.

On an identified date, interview with Personal Support Worker (PSW) #104, indicated resident #010 use the device when using the mobility aid as a restraint for safety due to high risk for falls. The PSW indicated the mobility aid was only used as PASD for positioning and or comfort. The PSW was unaware of the frequency of repositioning of the mobility aid.

On an identified date, interview with Physiotherapist (PT) by Inspector #111, indicated resident #010 uses the mobility aid for positioning and comfort.

Review of the current written care plan for resident #010, indicated the resident had several interventions in place related to restraints and the use of the mobility aid.

The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of restraint and or Personal Assistance Service Device (PASD), the plan of care was unclear as to whether the mobility aid was a restraint and or a PASD. The plan of care was unclear as to which mobility aid was currently in use, and the PSW was unaware of the frequency of repositioning of the mobility aid. [s. 6. (1) (c)]

2. On an identified date and time, resident #017 was observed by Inspector #571 using a mobility aid with a restraint device in place. On another identified date and time, resident #017 was observed by Inspector #111, with the same mobility aid and restraint device in place.

Review of the Progress Notes for resident #017, indicated the resident was assessed by the Occupational Therapist (OT) and the Physiotherapist (PT) on four different occasions to identify risk related to the resident position in the mobility aid. The PT and the OT identified risks, made several recommendations and put in place interventions related to proper positioning of resident #017's mobility aid, in consultation with the residents family.

Review of current written plan of care for resident #017, indicated there several interventions in place in relation to the mobility aid, as well as the a restraint device.

On an identified date, interview with Personal Support Worker (PSW) #106 by Inspector #111, indicated resident #017 use the restraint device when using the mobility aid. The PSW indicated the resident's mobility aid has to be positioned to aid with the residents movement and posture.

On an identified date, interview with a Registered Practical Nurse (RPN) by Inspector #111, indicated resident #017 use the restraint device, when using the mobility aid, and further indicated the restraint device was a PASD for positioning.

On an identified date, interview with Physiotherapist (PT) by Inspector #111, indicated resident #017 use the mobility aid for position and safety due to near miss falls. The PT indicated the Occupational Therapist (OT) who completed the assessments at the time, was no longer working at the home.

The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of restraint device, as there was no clear directions provided to staff regarding the use of the mobility aid as a restraint, which was put in place for safety and to restrict the residents movements. There was no clear direction related to how and or when the mobility aid was to be used as per the instructions by the OT. [s. 6. (1) (c)]

3. Related to Log #032758-16 involving resident #037:

A Critical Incident Report was submitted to the Director on an identified date, for an incident for which resident #037 sustained an injury and was taken to hospital.

On an identified date and time, a symbol/logo signage indicated that the resident uses two fall prevention devices.

Review of the current plan of care for resident #037 indicated, that the resident was at high risk for falls related to an unsteady gait and had four fall prevention interventions in place.

On an identified date, in an interview, Personal Support Worker (PSW) #141 and Registered Practical Nurse (RPN) #129, both indicated to the Inspector that resident #037 no longer uses the fall prevention devices, as the resident now uses a mobility aid, and did not have a fall since an identified incident.

On an identified date, interview the Resident Care Coordinator (RCC) #125 indicated, the home's expectation is that the written care plan is to be updated by the registered staff. The RCC #125 further indicated, that resident #037's care plan did not provide clear directions to staff, as the fall prevention devices, were no longer being used.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #037, as the logo/symbol on the communication board, indicated the resident uses fall prevention devices, when

these devices were no longer in use. [s. 6. (1) (c)]

4. The licensee has failed to ensure that plan of care was based on an assessment of the resident and the resident's needs and preferences.

A review of the current plan of care for resident #009, indicated the resident prefers to drink an identified beverage in between meals.

A review of the Progress Notes with an identified date, indicated resident #009 was out in hallway at an identified time, asking for an identified beverage. Registered Practical Nurse (RPN) #142 documented that he/she informed the resident it was too early to receive this beverage.

On an identified date, interview with the Registered Dietitian (RD) indicated, that resident #009 prefers to drink the identified beverage, and further indicated that beverages and other alternatives are available to residents of the home at all times. The RD indicated RPN #142 answer to resident #009 was not appropriate.

On an identified date, interview with the Director of Care (DOC) and the Resident Care Coordinator (RCC) #125, both indicated that if a nurse documents informing a resident that it is too early for an identified beverage, when the resident ask for the beverage, the nurse is not meeting the resident needs and preferences.

The licensee failed to ensure that plan of care was based on an assessment of the resident and the resident's needs and preferences, specifically related to resident #009 not receiving a beverage,when the resident requested it. [s. 6. (2)]

5. Related to Log #006134-17 involving resident #035:

A Critical Incident Report was submitted to the Director on an identified date, for an incident for which the resident sustained an injury and was taken to hospital.

A review of resident #035’s written plan of care, in place at the time of the incident, indicated the resident was independent with mobility and required one staff assistance with care.

A review of the Progress Notes with an identified date, indicated Personal Support Worker (PSW) #154 stated "while providing care to resident #035, the resident sustained an injury to a body part. The resident was then placed in a mobility aid by

two unidentified PSWs." Registered Practical Nurse (RPN) #163 documented contacting the Registered Nurse (RN) #162 to assess the resident, as resident #035 was visibly upset and voiced concerns of pain.

Interview with RN #162 indicated that prior to the above incident, resident #035 was independent with ambulation, and further indicated that when the RN came to assess resident #035, the resident was already seated in a mobility aid. The RN indicated that when the staff realized the resident was unable to weight bear, the staff should not have moved the resident, until the resident was assessed by the RN.

A review of the home Lift and transfer, policy # HRD-02-02-15, dated March 15, 2016, (Pg. 2 and 4/10) directs:

Assisted transfer (one person, two person assist), the resident must be able to weight bear reliably throughout the transfer.
All resident care providers are responsible to determine the suitability of the transfer level prior to each and every resident transfer.
Transfer Status Changes:
1. If the transfer status of the resident changes, resident care providers must consult the unit RN who will change and post temporary logo as needed. The RN will send a referral to the Physiotherapist/Occupational Therapist (PT/OT) to reassess the transfer status of the resident, for reassessment of the resident.

Interview with the DOC indicated the home's expectation is, generally, if someone is injured they should not be transferred, until they are assessed.

The licensee failed to ensure the plan of care based on an assessment of resident #035's needs and preferences, as the resident sustained an injury and was assisted to a mobility device by two staff, before being assessed by a RN. [s. 6. (2)]

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

A review of resident #010 written care plan and dietary binder, indicated the resident was to receive a specific diet. Further review of Progress Notes on an identified date, and documentation by the Registered Dietitian (RD), indicated the RD recommended to continue with current diet and fluids.

On an identified date and time, resident #010 was observed in a specific area drinking fluids that were not ordered or recommended by the RD.

On an identified date, interview with Personal Support Worker (PSW) #118, indicated to the Inspector #607, that resident #010 receives specific diet as well as fluids

On an identified date and time, interview with Registered Practical Nurse (RPN) #119 indicated to the Inspector, that resident #010 should be receiving specific fluid and the resident sometimes grabs other residents' fluids.

On an identified date, interview with the Registered Dietitian (RD), by Inspector #607, indicated that resident #010 should be receiving a specific fluid and sometimes grab other residents' fluids. The RD further indicated, that staff are to be aware of the fluids left around the resident, and to ensure that specific fluids that were not ordered for the resident, were out of the residents' reach.

On an identified date, interview with the DOC, by Inspector #607, indicated the home’s expectation is, if a resident is receiving a special diet, the staff are to adhere to that specific diet.

The licensee failed to ensure the care set out on the plan was provided to resident #010 as specified, specifically related fluid consistency. [s. 6. (7)]

7. Related to Log #026615-16 involving resident #023:

A Critical Incident Report was submitted to the Director on an identified date, regarding an incident for which the resident #023 sustained an injury, was taken to hospital, and which resulted in a significant change in the resident’s health status.

Resident #023 has medical diagnoses which includes cognitive impairments. The resident #023 required limited assistance with activities of daily living (ADL), and was a known falls risk, having had falls prior to admission.

The clinical health record, for a three month period, was reviewed by Inspector #554, on two identified dates, and indicated resident #023 had several interventions in place related to a mobility aid, and indicated the resident required assistance with activities of daily living. Further review of the plan of care, identified that resident #023 had risk related to history of falls, as the resident attempts to

self-transfer and had three fall prevention interventions in place.

A review of the Progress Notes for resident #023, indicated the resident was assessed by the Occupational Therapist (OT), risk were identified related to falls and several interventions were put in place, in consultation with the registered staff and the resident family.

Further review of the Progress Notes indicated on an identified date, "the Personal Support Worker (PSW) was redirecting resident #023 to a specific area, when the resident tripped over a fall prevention device. The resident fell and complained of pain. The staff notified Registered Practical Nurse (RPN), who notified Registered Nurse (RN). The Registered nursing staff attempted to assess the resident, but the resident continued to indicate pain. The Physician was notified of the fall and injury. Resident #023 was transferred by ambulance to hospital for further assessment."

Resident #023 was diagnosed, at the hospital, with an injury to a body part, and was later returned to the Long-Term Care home.

Post Falls Assessment/Huddle, was completed by a Registered Practical Nurse and dated an identified date, identified that the fall prevention device, which was in a specific area, at the time of resident's fall, presented a trip hazard and was a contributing factor to the resident #023's fall, and subsequent injury.

During interviews with Personal Support Workers (PSW) #134, #151, and Registered Nurse (RN) #113, indicated to Inspector #554, on an identified date in that fall prevention devices are utilized as a fall prevention strategy, and are to be used only at a certain time period for identified residents. The PSWs and the RN indicated that fall prevention devices are to be taken from certain areas if not in use, as they, the devices, present as a trip/fall hazard. Personal Support Worker #134, and RN #113, both indicated to Inspector #554, that the removal of fall prevention devices from an identified area during a certain time period is a "normal practice."

During an interview, the Director of Care indicated to Inspector #554, on an identified date that staff are aware that fall prevention devices are not to be left on a specific area, during a specific time period.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #023, related to resident's fall prevention interventions. [s. 6. (7)]

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

Related to Log #006134-17 involving resident #035:

A Critical Incident Report was submitted to the Director on an identified date, for an incident where a resident sustained an injury, for which a resident was taken to hospital.

A review of the Physiotherapist (PT) assessment with an identified date, indicated resident #035 utilizes a mobility aid as a primary mode of locomotion, and requires one staff assist with the locomotion of the mobility aid. Further review of the Fall Assessment Tool (FRAT) completed on an identified date, indicated resident #035 was at moderate risk for falls.

On two identified dates and three identified times, resident #035 was observed in a mobility aid, with a fall prevention device in place, and made several attempts to self-transfer from the mobility aid. At each observation, the fall prevention device was activated and staff responded.

A review of resident #035's current written plan of care that the Personal Support Worker (PSW) have access to, and indicated the resident is ambulatory.

On an identified date, interview with PSW #156 and Registered Practical Nurse (RPN) #135, indicated to Inspector #607, that resident #035 is not ambulatory, and uses a mobility aid to assist with ambulation.

On an identified date, interview with RPN #156 and RN #155, both indicated to Inspector #607, that resident #035 uses a mobility aid to assist with ambulation; they further indicated that resident #035's plan of care was not updated to include the resident ambulation status.

The licensee failed to ensure that when resident #035 was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, specifically related to the resident current ambulation status. [s. 6. (10)

(b)]

Additional Required Actions:

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

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan specifically related to resident #023 and #035, the care set out in the plan of care is based on an assessment of the resident and the needs and preferences, specifically related to resident #009 and #035 and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, a goal in the plan is met; the resident's care needs change or care set out in the plan is no longer necessary, specifically related to resident #035, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under O. Reg. 79/10, s. 48 (1) - Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home, specifically a Falls Prevention and Management Program, to reduce the incidence of falls and the risk of injury.

Under O. Reg. 79/10, s. 49 (1) - The Falls Prevention and Management Program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assisstive aids.

The licensee's Head Injury Routine policy (#INTERD-03-01-01) with an identified review date, which is part of the Falls Prevention and Management Program, stated that registered nursing staff will initiate a head injury routine when there is a documented or suspected head injury or as ordered by a Physician, Nurse Practitioner, or a Registered Nurse. Abnormal findings are reported to the Physician/Nurse Practitioner promptly.

The policy (#INTERD-03-01-01) defines head injury as any traumatic insult to the brain that results in physical, intellectual, emotional, social or vocational changes. Types of head injuries include, contusion and haematoma. Residents will be monitored for changes which may indicate a need for further medical intervention.

The policy (#INTERD-03-01-01) directs:

a) Registered nursing staff will monitor the following:
- Level of consciousness (LOC) using the Glasgow Coma Scale
- Pupil Response
- Strength of extremities and grasp response
- Changes in behaviour, including lethargy
- Drowsiness, confusion, disorientation, agitation
- Dizziness, nausea, vomiting or severe headache
- Bleeding or cerebral spinal fluid from ears and or nose
- Vital signs (VS)

b) Abnormal findings are reported to the Physician or Nurse Practitioner promptly.

c) Document observations on progress notes and appropriate records.
d) Continue Head Injury Routine as per protocol, unless otherwise directed by the Physician, Nurse Practitioner or a Registered Nurse.

Related to Log #032429-16 involving resident #038:

A Critical Incident Report was submitted to the Director, related to an incident that occurred on an identified date and time, that resulted in an injury, for which the resident was taken to hospital, and which resulted in a significant change in the resident's health status.

Resident #038 has a medical diagnoses which includes cognitive and physical impairment.

During interviews, Registered Nurse (RN) #113, Personal Support Worker (PSW) #143, and Resident Care Coordinator (RCC) #125 indicated to Inspector #554, on an identified date, that resident #038 was known to be at risk for falls and required the use of a restraint device, due difficulties maintaining position or posture while using a mobility aid.

A review of the clinical health records indicated the Occupational Therapist (OT) and the Physiotherapist (PT) documented resident #038 as having poor posture and/or positioning, in various progress notes and assessments, hence the need for the device, as a positioning restraint.

The clinical health record, for resident #038, was reviewed by Inspector #554, with the following documented:

Resident #038 was on a medication therapy that was prescribed to be given daily. The Medication Administration Record (MAR) indicated that resident #038 had been administered the prescribed medication ten identified dates in an identified month.

A review of the Written Care Plan, indicated resident #038 had several interventions in place related transfers, mobility, falls and the application of a restraint.

A review of the Progress Notes for an identified time period indicated the following:
- Registered Nurse (RN) #113 was called to a specified area by Personal Support

Worker (PSW) #143, who reported that resident #038 had fallen. PSWs #143 and #144, reported that they had provided care to the resident, and transferred the resident via a mechanical device to his/her mobility aid. PSW #143 left PSW #144 and resident #038 to obtain a piece of linen. During this time, PSW #144 bent over to obtain the resident's restraint device, when the resident leaned forward and fell.

As per RN #113's assessment, "resident #038 sustained injuries and the RN #113 applied treatment to the injured areas.

Further review of the progress notes indicated that resident #038 was assessed by RN #147, RPN #159 and RPN #158, and the documentation indicated detailed changes in the resident's physical status, that constituted an abnormal findings.

At an identified date and time, the resident physical status had changed, RN #147 was called to assess the resident and the SDM (Substitute Decision Maker) was notified. The On-Call Physician was also notified and the resident was transferred to hospital for further assessments.

Registered Practical Nurse (RPN) #159 indicated to Inspector #554, that he/she had worked on an identified date. The RPN #159 indicated when he/she came on shift, he/she was given report from the off-going RPN, who told him/her that resident #038 had fallen earlier that day, and had sustained an injury to a body part, and was on head injury monitoring. RPN #159 indicated resident #038 had remained in bed during his/her shift, due to changes in the residents physical status. In addition, RPN #159 indicated being concerned that resident #038 continued to have changes related to the residents physical status. RPN #159 further indicated reporting his/her concerns to Registered Nurse (RN) #147, and was told by RN #147 and an unidentified RN to monitor the resident. RPN #159 indicated to Inspector #554 that he/she felt that the Physician should have been contacted, as resident #038 symptoms suggested a change in condition post fall with injury. The RPN indicated it was the role of the RN, who was the Charge Nurse, to contact the Physician.

Personal Support Worker #144, Registered Practical Nurse #157, #158, and #160 were not available for interviews during this inspection. Registered Nurse #147, who was the Charge Nurse on the shift the resident fell, was no longer employed by the Long-Term Care home, and was unable to be interviewed during this inspection.

Registered Nurse #113 and #130, who are Charge Nurses, indicated that the licensee's Head Injury Routine policy #INTERD-03-01-01, indicated that abnormal changes assessed in a resident during an injury monitoring, are to be reported to the Physician and or Nurse Practitioner (NP).

Registered Nurse #113, reviewed the Progress Notes for two identified dates, with Inspector #554. RN #113 indicated that the documentation detailed changes in the resident's physical status that constituted abnormal findings. RN #113, who was the assigned Charge Nurse on two identified dates when the incident occurred, indicated a Physician should have been notified sooner, as per the licensee's Head Injury Routine policy #INTERD-03-01-01.

The licensee failed to ensure that the Head Injury Routine policy #INTERD-03-01-01 was complied with, specifically related not notifying the Physician immediately, when the resident physical status changed. [s. 8. (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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically related to the licensee Head Injury Routine policy #INTERD-03-01-01, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to Log # 028928-16 involving resident #030:

A Critical Incident Report was submitted to the Director on an identified date for an incident of resident to resident abuse. The CIR indicated on an identified date, a visitor reported to Registered Practical Nurse (RPN) #124 that resident #030 was exhibiting responsive behaviours towards resident #031. The CIR indicated resident #030 had prior incidents of responsive behaviours towards other residents in the past six months and some resulted in injury.

Review of the Progress Notes for resident #030 indicated there were two additional incidents of resident to resident abuse resulting in injury, that occurred over a three month period, that were not investigated (refer to WN #001).

On an identified date, interview with both the Director of Care (DOC) and the Resident Care Coordinator (RCC) by Inspector #111, indicated the two incidents of resident to resident abuse were not investigated. [s. 23. (1) (a)]

2. Related to Log #'s 028510-16 and 032817-16 involving resident #029, #028, and #034:

A Critical Incident Report was submitted to the Director on an identified date, for a suspected incident of resident to resident abuse. The CIR indicated on an identified date and time, resident #034 was found in a specified area, with multiple injuries to his/her body parts. Resident #028 was observed leaving the specified area, just prior to the discovery of the injuries to resident #034. Both residents are cognitively impaired. Resident #028 was monitored for three days by a Staff Member, and a seven day Dementia Observation Tool (DOS) was implemented to identify triggers.

A second Critical Incident Report was submitted to the Director on an identified date, for a witnessed incident of resident to resident abuse. The CIR indicated at an identified time, resident #028 was observed in a specified area that was being monitored by a staff member.The Staff Member attempted to redirect resident #028 out the specified area. Resident #028 had an altercation with resident #029 which resulted in injury. A referral for consultation was initiated, and a personal monitoring device was also provided the Staff Member.

Review of the Progress Notes for resident #028 and resident #029, indicated there was a third incident that occurred on an identified date and time, when resident #028 had entered a specific area. Resident #053 was visiting the specific area at the time. Resident #029 & #053 had an altercation with resident #028, which resulted in pain and injury to resident #029. Two days later, resident #029 was assessed by the Physician who indicated resident #029 sustained an "injury to a body part. A laboratory test was ordered and the results were negative.

Review of the Progress Notes for resident #029 and resident #058 indicated on an identified date and time, a Staff Member witnessed and altercation between resident #029 and #058. When the staff approached the residents, resident #029 walked away and denied anything had occurred. Resident #058 pointed to resident #029 and then pointed to his/her body part. Resident #058 was noted to have four injuries to a body part.

On an identified date, interview with the DOC by Inspector #111, indicated the two incidents in two identified months of resident to resident abuse were not investigated, and appropriate actions were not taken to prevent a reoccurrence. [s. 23. (1) (a)]

3. Related to Log #'s 028510-16 and 032817-16 involving resident #029:

A Critical Incident Report was submitted to the Director on an identified date, for a witnessed incident of resident to resident abuse. The CIR indicated at an identified time resident #028 was observed wandering into a specified area, and indicated that resident #029 was being monitored by a Staff Member. The Staff Member attempted to redirect resident #028 out of the specific area. Resident #029 had an altercation with resident #028 resulting in injury to resident #029.

On an identified date, interview with Personal Support Worker (PSW) #102 and Registered Practical Nurse (RPN) #103 by Inspector #111, indicated resident #028 no longer demonstrated any responsive behaviours. They both indicated resident #029 demonstrated responsive behaviours towards other residents and recently and had just injured another resident.

Review of the Progress Notes for resident #028 #029, #053, #054, #055, #056, #057, #058, #059, #060 indicated resident #029 had demonstrated ongoing incidents of responsive behaviours towards several residents, some residents more than one occasion (Refer to WN #001).

On an identified date, interview with the DOC by Inspector #111, indicated there were no investigations completed into the above incidents. [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 ensuring that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, which includes abuse of a resident by anyone, specifically related to resident #029 and #030, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that 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: Abuse of a resident by anyone.

Related to Log # 028928-16 involving resident #030:

A Critical Incident Report was submitted to the Director on an identified date, for an

incident of resident to resident abuse. The CIR indicated on an identified date, a visitor reported to Registered Practical Nurse (RPN) #124 that resident #030 was witnessed exhibiting responsive behaviours towards resident #031 The CIR indicated resident #030 had prior incidents of responsive behaviours towards other residents in the past six months and some resulted in injury.

Review of the Progress Notes for resident #030 indicated there were two additional incidents of resident to resident abuse resulting in injury, that occurred on two identified dates that were not reported to the Director (refer to WN #001).

On an identified date, interview with both DOC and RCC by Inspector #111, indicated the two incidents of resident to resident abuse were not reported to the Director. [s. 24. (1)]

2. Related to Log #'s 028510-16 and 032817-16 involving resident #029:

A Critical Incident Report was submitted to the Director on an identified date, for a witnessed incident of resident to resident abuse. The CIR indicated at an identified time, resident #028 was observed wandering into an identified area where resident #029' was located and was being monitored by a Staff Member The Staff Member attempted to redirect resident #028 out of the specific area. Resident #028 had an altercation with resident #029 which resulted in injury.

Interview with Personal Support Worker (PSW) #102 and Registered Practical Nurse (RPN) #103 by Inspector #111, indicated resident #028 no longer demonstrated any responsive behaviours. They both indicated resident #029 demonstrated responsive behaviours towards other residents and recently and had just injured another resident.

Review of the Progress Notes for resident #028 #029, #053, #054, #055, #056, #057, #058, #059, #060 indicated resident #029 had demonstrated ongoing incidents of abuse towards several residents, some residents more than one occasion (refer to WN #001).

On an identified date, interview with RCC #125 by Inspector #111, indicated to the RCC became aware of the incident between resident #029 and resident #058, two days post incident. The RCC indicated he/she spoke to RPN #148 regarding the incident upon the RPN returning to work, two days later. The RCC indicated the incident was not reported to the Police or the Director, because the incident was

not witnessed. The RCC indicated he/she would only report suspected incidents of abuse if there was a repeated pattern or intent to injure. In addition, the RCC indicated because both residents have cognitive impairments, they decided the incidents were not reportable, and further indicated when he/she spoke to RPN #148, the actions taken was a referral to Behaviour Support Ontario (BSO) team, to assess the resident.

On an identified date, interview with the DOC by Inspector #111, indicated the above incidents were not reported to the Director. [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 ensuring that 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: Abuse of a resident by anyone, specifically related to resident #029 and #030, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to Log #032429-16 involving resident #038:

Interviews with Registered Nurse (RN) #113, Personal Support Worker (PSW) #143, and the Resident Care Coordinator (RCC) #125, indicated to Inspector #554, on an identified date, that resident #038 was known to be at risk for falls, required restraint device, due to the resident having difficulties maintaining his/her positioning or posture, while using the mobility aid.

The Occupational Therapist (OT) and the Physiotherapist (PT) have also documented resident #038 as having poor posture and/or positioning, in various progress notes and assessments, over a year period, and during the OT/PT's last assessment on an identified date. The Occupational Therapist reiterated, to Inspector #554, on an identified date, that resident #038 was at risk for falls, related to his/her inability to maintain position and or posture while using mobility aid, hence the need for a restraint device.

The clinical health record, for resident #038, was reviewed by Inspector #554, and the following documentation were noted:

The Written Care Plan with an identified date had several interventions in place related to transfers, falls and restraint.

A review of the Progress Notes for an identified time period, indicated the following:
- Registered Nurse (RN) #113 was called to a specific area by Personal Support Worker (PSW) #143, who reported that resident #038 had fallen to the floor. PSW's #143 and #144, reported that they care for the resident, and transferred the resident via a mechanical device to his/her mobility aid. PSW #143 left PSW #144 and resident #038 to obtain a piece of linen, during this time, PSW #144 bent over to obtain the resident's restraint device, when the resident leaned forward, fell to the floor.

Further review of the progress notes indicated that resident #038 was assessed by RN #147, RPN #159 and RPN #158 and the documentation detailed changes in the resident's physical status, that constituted abnormal findings.

At an identified time and date, it was noted that the resident physical status had changed and RN #147 was called to assess the resident. The SDM (Substitute Decision Maker) and the On-Call Physician was notified of the incident, by RN

#147. The resident was transferred and admitted to hospital for further assessments.

During an interview, Personal Support Worker (PSW) #143 indicated, to Inspector #554, on an identified date, that PSW #144 and him/herself, removed resident #038 to specified area via a mechanical device and placed the resident into a mobility aid, but did not place the restraint device onto the mobility aid. PSW #143 indicated, to Inspector #554, that he/she had left resident #038 and PSW #143 to obtain a piece of linen. PSW #143 indicated hearing PSW #144 scream, and turned to see resident #038 lying on a specific area. PSW #143 indicated being aware that resident #038 was known to have poor posture, and needed a restraint device to ensure an upright position while using the mobility aid.

During an interview, Registered Nurse (RN) #113, who was the Charge Nurse on an identified date, indicated to Inspector #554, on two identified dates, that he/she had been called to the specified area to assess resident #038 who had fallen. RN #113 indicated he/she had being told by PSW #143 and #144 that they had not placed the required restraint device on resident #038's mobility aid, prior to PSW #143 walking away, and or PSW #144 turning away from resident #038 to pick up the restraint device.

Personal Support Worker #144 was not available for an interview during this inspection.

During interviews, Registered Nurse #113 indicated to Inspector #554 on two identified dates, that resident #038 should have been properly positioned with the restraint device in place, prior to PSW #143 walking away and or PSW #144 turning away from the resident.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #038, by not properly positioning the resident restraint device prior to PSW #143 walking away, and or PSW #144 turning away from the resident, resulting in the resident sustaining a fall. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. Specifically related to ensuring two staff are actively involved in the transfer and positioning of residents, who require to have two staff present, to be implemented voluntarily.

WN #7: 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 has failed to ensure that the resident’s substitute decision-maker, if any, and any other person specified by the resident, 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 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.

Related to Log # 032817-16 involving resident #029:

Review of the Progress Notes for resident #029 and resident #058 indicated on an identified date and time, a staff member witnessed and altercation between resident #029 and #058. When staff approached the residents, resident #029 walked away and denied anything had occurred. Resident #058 pointed to resident #029 and then pointed to his/her body part. Resident #058 was noted to have four injury to a body part. There was no documented evidence to indicate the Substitute Decision Makers (SDM) were notified of the incident.

On an identified date, interview with RPN #148 indicated unable to recall whether the SDM's were notified of the incident. [s. 97. (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 ensuring that the resident's substitute decision-maker, if any, and any other person specified by the resident, 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 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, specifically related to resident #029, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Log #028928-16 involving resident #030 and #032:

A Critical Incident Report was submitted to the Director on an identified date, for an incident of resident to resident abuse. The CIR indicated on an identified date, a visitor reported to Registered Practical Nurse (RPN) #124 that resident #030 was witnessed exhibiting responsive behaviours towards resident #031. The CIR indicated resident #030 had prior incidents of responsive behaviours towards other residents in the past six months and some resulted in injury.

Review of the Progress Notes for resident #030 indicated there were two additional incidents of resident to resident abuse resulting in injury, that occurred on two identified dates.(Refer to WN #001).

On an identified date, interview with both Director of Care (DOC) and the Resident Care Coordinator (RCC) #125 by Inspector #111, indicated the two incidents of resident to resident abuse were not reported to the police. [s. 98.]

2. Related to Log #'s 028510-16 and 032817-16 involving resident #028, #029 and #058:

A Critical Incident Report was submitted to the Director on an identified date, for a witnessed incident of resident to resident abuse. The CIR indicated at an identified time, resident #028 was observed ambulating in a specific area where resident #029 was located and was being monitored by a Staff Member. The Staff Member attempted to redirect resident #028 out of resident specific area. Resident #028 had an altercation with resident #029, which resulted in injury.

A review of the Progress Notes for resident #028, #029 and #058 indicated there were two additional incidents of resident to resident abuse that occurred on two identified dates, that resulted in injury.

On an identified date, interview with the Director of Care (DOC) by Inspector #111, confirmed these two incidents of resident to resident abuse, were not reported to the Police. [s. 98.]

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 ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, specifically related to resident #028, #029, #030, #032 and #058, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On an identified date and time, Personal Support Worker (PSW) #102 was observed entering a specific area where a resident was located. The Staff Member was required to wear Personal Protective Devices (PPE) during care. The Personal Support Worker (PSW) was responding to a response communication system. The PSW then came back out of the specified area, wearing two PPEs, and then re-entered the specific area to assist the resident with care. The PSW was observed not wearing a required PPE. The specific area had a contact precaution sign in place, that indicated three PPEs must worn at all times. There were clean Personal Protective Equipments (PPE) located outside the specific area. The PSW then left the specific area wearing only one PPE, carried the soiled linen and product down a specified area to the soiled linen carts.

On an identified date, interview with PSW #102 by Inspector #111, indicated the soiled linens and product was for a resident and indicated that they do not take the soiled linen carts down to specific areas of the home.

On an identified date, interview with Registered Practical Nurse (RPN) #103 by Inspector #111, indicated the resident specified area required the use of PPEs to worn at all times. The RPN indicated PSWs are supposed to take a bag with them to resident specific areas that requires the use of PPEs, to dispose of soiled products and or clothing, and securely carry these to the soiled linen carts.

On an identified date, interview with the DOC by Inspector #111, indicated the expectation is, staff are not to carry soiled linens and products throughout specific areas of the home, and are required to use appropriate PPEs when entering resident specific areas that requires the use of PPEs. [s. 229. (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 ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

O. Reg. 79/10, s. 2(1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

O. Reg. 79/10, s. 2(1) (b) defines verbal abuse as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

The licensee has a current Compliance Order (CO) outstanding under LTCHA, s.19(1).

Related to Log #'s 028510-16, 032817-16 and 028928-16 involving resident #029 and #030:

A Critical Incident Report was submitted to the Director on an identified date, for a witnessed incident of resident to resident abuse. The CIR indicated at an identified time, resident #028 was observed ambulating into a specific area where resident #029 was located, and who was being monitored by a Staff Member. The Staff

Member attempted to redirect resident #028 out of the specific area where resident #029's was located. Resident #028 had an altercation with resident #029 which resulted in injury.

On an identified date, interview with Personal Support Worker (PSW) #102 and Registered Practical Nurse (RPN) #103 by Inspector #111, both indicated resident #028 no longer demonstrated any responsive behaviours They both indicated resident #029 demonstrated responsive behaviours towards other residents and recently and had just injured another resident.

A review of the clinical health care records, indicated there were several incidents, where residents were not protected from abuse from resident #029 as follows:
-Review of the Progress Notes for resident #029 indicated there were ongoing incidents of abuse towards several residents: #028, #053, #054, #055, #056, #057, #058, #059, #060, some residents on more than one occasions. One incident between resident #028 and #029 that occurred on an identified date, resulted in injury to resident #029 (see WN #01 for details).

A review of the clinical health care records, indicated several residents were not protected from abuse by resident #030 as follows:
-Review of the Progress Notes for resident #030 indicated that there were ongoing incidents of abuse towards other residents: #031, #032, and #049, some on more than one occasions. Two incidents involving resident #030 and #031 resulting in pain or injury to resident #031, that occurred on two identified dates (see WN #01 for details).

-The licensee failed to ensure there were immediate investigations completed into several incidents of alleged, suspected or witnessed incidents of abuse that occurred on several identified dates, as identified under LTCHA, s. 23 (1)(a).
-The licensee failed to ensure that all the incidents on the above identified dates that resulted in harm or risk of harm to ten residents were reported to the Director, as identified under LTCHA, 2007, s.24(1).
-The licensee failed to ensure the police were notified of four incidents of resident to resident abuse, as identified under O.Reg. 79/10, r.98.
- The licensee failed to ensure an incident of suspected resident to resident abuse that resulted in injury that occurred ion identified date, was reported to either resident's Substitute Decision Makers (SDM), as identified under O.Reg. 79/10, r.97(1)(a).
-The licensee failed to ensure that steps were taken to minimize the risk of

altercations and potentially harmful interactions between and among residents, as identified under O.Reg. 79/10, s.54 (a).

Therefore, considering the licensee has a current Compliance Order (CO) outstanding under LTCHA, s.19(1), the following actions are being taken: A Compliance Order is being issued under O.Reg. 79/10, s.54 (a) and Voluntary Plan of Corrections (VPC) are being issued under O.Reg. 79/10, r.98, s.24(1), s. 23 (1) (a) and r.97(1)(a). [s. 19. (1)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Restraint Minimization policy was complied with.

Review of the licensee's "Restraint Minimization" policy (#INTERD-03-04-01) revised January 2017, indicated under procedure for the use of physical restraints (on page 3 of 11) directs:
-obtain and record informed consent from resident or substitute decision maker.
-document discussion and consent using the Alternative Treatments to Restraints Form.
-once the documentation of the consent and discussion is completed, the registered nursing staff will communicate with the nursing care team and will initiate the monitoring flow sheet.

Observation of resident #017 by Inspector #571 and #111 on two separate days and times, indicated the resident was observed with the use of a mobility aid, and a restraint device in place.

On an identified date, interview with Personal Support Worker (PSW) #106 by Inspector #111, indicated resident #017 use a restraint device to assist with positioning while using a mobility aid.

On an identified date, interview with the Physiotherapist (PT) by Inspector #111, indicated resident #017 had been changed from a restraint mobility aid to another mobility aid that required restraint, due to two near missed incidents of falling from the mobility aid.

Review of the Progress Notes for resident #017, indicated the mobility aid was in use since an identified date, which was used as a restraint to limit the resident's movement and for safety.

There was no documented evidence of a Physician or Nurse Practitioner (NP) Order, no Record of Consent to Treatment, no Restraint Form, or Alternative Treatments to Restraints Form completed for the use of the mobility aid (only for the restraint device), that was in use since an identified date, as per the licensee's policy. [s. 29. (1) (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: A Physician, Registered Nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Observation of resident #017 on an identified date, by Inspector #571, indicated the resident was in a mobility aid with the use of a restraint device in place. On another identified date, Inspector #111, indicated the resident uses the mobility aid with a restraint device in place.

On an identified date, interview with staff and review of the resident #017 health record, indicated the mobility device was put in place, as recommended by the Occupational Therapist (OT) to limit the resident movement and for pressure relief. On two identified dates, the resident had two near miss falls when the resident's mobility aid was not positioned as per instruction by the OT. The mobility aid therefore restricted the movement of the resident.

Review of the Physician Orders indicated an order was received on an identified date, for the restraint device, but there was no documented evidence of a Physician Order or an Order by the Nurse Practitioner (NPEC) regarding the use of the restraint device. [s. 31. (2) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids, labelled within 48 hours of admission and of acquiring, in the case of new items, and were cleaned as required.

The following items were observed on an identified date, by Inspector #111 in two identified areas during the initial tour of the home on three separate units:
-Three hairbrushes with several grey hair sitting on the counter with no resident label in place.There were also two large and two small nail clippers sitting on the counter in use with no resident names on them.

The following items were observed on another identified date by Inspector #111, in two identified areas on two units:
- A small nail clippers that was used, sitting on the counter with no resident label in place, and one hair brush with several grey hair sitting on the counter with no resident label in place.

On an identified date, interview with PSW #104 indicated no awareness of who the hair brushes belonged to,and indicated the hair brushes should have been labelled. The PSW threw the hair brushes in the garbage.

Interview with PSW #106 indicated no awareness of who the nail clippers belonged to and indicated they should have had a resident label on them. [s. 37. (1) (a)]

Issued on this 8 day of September 2017 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JULIET MANDERSON-GRAY (607) - (A2)

Inspection No. / No de l'inspection : 2017_639607_0013 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005944-17 (A2)

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

Report Date(s) / Date(s) du Rapport : Sep 08, 2017;(A2)

Licensee / Titulaire de permis : REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

LTC Home / Foyer de SLD : FAIRVIEW LODGE
632 DUNDAS STREET WEST, P.O. BOX 300,
WHITBY, ON, L1N-5S3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Marcey Wilson

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To REGIONAL MUNICIPALITY OF DURHAM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee shall prepare, implement and submit a corrective action plan to ensure that
procedures and interventions are developed and implemented to assist residents who are at risk of harm or who are harmed as a result of resident's behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, including but not limited to the following:

1) Ensuring the Behaviour Support Ontario (BSO) team is notified immediately of all residents, including resident #029, demonstrating altercations and potentially harmful interactions between and among other residents.
2) Ensuring BSO and the interdisciplinary team identify factors that could potentially trigger such altercations and potentially harmful interactions. Identify and implement interventions to manage these responsive behaviours through appropriate assessments (i.e. BAT/PIECES/DOS).
3) Develop and implement a process to ensure the plan of care for those

residents is reviewed and revised to incorporate the interventions identified by the BSO and the interdisciplinary team, to manage these responsive behaviours.
4) Develop and implement a process to ensure all staff providing care to those residents know which of the residents are at risk for altercations and potentially harmful interactions, and understand how and when to implement the planned interventions to manage responsive behaviours.
5) Review the content of the licensee Responsive Behaviour Prevention and Management policy #INTERD-03-09-01 and the BSO program with all nursing staff, to ensure they are aware of their roles and responsibilities related to managing residents demonstrating the risk of altercations and potentially harmful interactions between and among residents.
6) Develop and implement a monitoring tool to ensure the planned, revised interventions and strategies are effective in managing the responsive behaviours of resident #029, with special attention to minimizing risks associated with potential harmful interactions between resident #029 and other residents.
7) Develop and put in place a process whereby the Director of Care and or delegates are reviewing all documentation and communication from the front line staff at least daily to determine if any high risk responsive behaviours have occurred in the home; and this shall continue until compliance is achieved.

The plan shall be submitted on or before August 9, 2017, to LTCH Inspector-Nursing Juliet Manderson-Gray via fax at 613-569-9670 or via email at OttawaSAO.MOH@ontario.ca. The plan shall identify who will be responsible for each items and expected completion dates.

Grounds / Motifs :

(A2)
1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations and by identifying and implementing interventions.

Related to Log # 028928-16 involving resident #030, #031, #032 and #049:

A Critical Incident Report was submitted to the Director, for an incident of resident to resident abuse involving resident #030. The CIR indicated on an identified date, a visitor reported to Registered Practical Nurse (RPN) #124 that resident #030 was witnessed exhibiting responsive behaviours towards resident #031. The CIR also indicated resident #030 had prior incidents of responsive behaviours towards other residents in the past, and some resulted in injuries.

Review of the written plan of care, in place at the time of incidents, for resident #030 related to responsive behaviours, indicated the resident had several interventions in place.

On an identified date, interview with PSW #134 by Inspector #111, indicated resident #030 wanders around the unit with the use of a mobility aid independently, but does exhibit responsive behaviours towards other residents.

On an identified date, interview with the Behaviour Supports Ontario (BSO) RPN #126 by Inspector #111 indicated the BSO team currently enters the BSO information directly into the resident's Progress Notes which includes the responsive behaviours exhibited, triggers and strategies to manage the behaviours. The RPN indicated they also initiate any behaviour monitoring tools put in place, receive electronic referrals from the registered staff, and further indicated a referral was received after the incident involving resident #030 and #031. The RPN indicated the resident did have prior incidents of resident to resident responsive behaviours, but was not placed in the BSO program until after the incident on an identified date. The RPN indicated resident #030 demonstrated several responsive behaviours towards staff and other residents. The RPN indicated resident #030 was cognitively impaired and indicated the BSO program created a communication device for staff and or resident to use to improve communication of the resident needs. The RPN indicated the resident also had a Dementia Observation System (DOS) implemented for four days after the incident, and further indicated that a Behavioural Assessment Tool (BAT) was completed. The RPN indicated he/she would then use the BAT to update the resident's written care plan.

Review of the Progress Notes for resident #030, #031, #032 and #049 related to responsive behaviours, indicated there were several incidents over a four month period, involving resident #030. Further review of the health care records for resident #029, #030, #032 and #049 and interview of staff indicated all four residents were cognitively impaired.

A Behavioural Assessment Tool (BAT) and a Physical, Intellectual, Emotional Capabilities, Environmental and Social Culture (PIECES) assessment was completed on an identified date, ten days after the incident that occurred. The PIECES indicated resident #030 was exhibited responsive behaviours towards other residents. The BAT, indicated resident #030 demonstrated responsive behaviours and identified several triggers and interventions.

A Dementia Observation Scale (DOS) was completed, days after the incident had occurred, and indicated the resident had no responsive behaviours during that time period.

The Progress Notes indicated, there were several incidents of resident to resident responsive behaviours and potentially harmful interactions that resident #029 exhibited towards other residents, two resulting in injury. There was no documented evidence that an interdisciplinary assessment was completed to identify factors that could potentially cause the resident's trigger. The altercations and interventions were not identified and or implemented until five to ten days after an identified incident.

The interventions were also not implemented after the last incident, and the written plan of care was not updated to reflect the assessment (BAT) completed. [s. 54. (a)]

2. Related to Log #'s 028510-16 and 032817-16 involving resident #029:

Review of the Progress Notes for resident #029 over a four month period, indicated the resident was involved in several incidents of resident to resident responsive behaviours towards three different residents (resident #028, #054, and #055), and on more than one occasion. There were no further documented incidents of responsive behaviours until several months later, when resident #029 began demonstrating responsive behaviours towards other residents (resident #057, #058, #059 & #060).

On an identified date, interview with Personal Support Worker (PSW) #102 by Inspector #111, indicated resident #029 had not had any responsive behaviours until a few weeks prior, when staff started to noticed the resident exhibiting responsive behaviours towards other residents who are cognitively impaired, and further indicated resident #029 had responsive behaviours two weeks prior, with another resident that resulted in injury.

On an identified date, interview with RPN #148 by Inspector #111, indicated after the incident occurred between resident #029 and resident #058, the RPN monitored resident #029 for the remainder of the shift, and indicated he/she probably reported the incident to the Registered Nurse (RN), but could not recall who the RN was.

A review of the written plan of care for resident #029 related to responsive Behaviours, in place at time of incidents, indicated resident #029 demonstrated several responsive behaviours, and had several interventions in place. The care plan was updated on two identified dates. A BSO referral was completed on another identified date, in regards to the resident's responsive behaviours.

A Physical, Intellectual, Emotional Capabilities, Environmental and Social Culture (PIECES) assessment was completed on an identified date. There was no documented evidence to indicate actions had been taken to prevent risk of injury or harm to others.

A Behavioural Assessment Tool (BAT) was completed on an identified date, and this was completed before the escalation of responsive behaviours towards other residents.

On an identified date, interview with the Resident Care Coordinator (RCC) #125 by Inspector #111, indicated the incident had occurred on a weekend and the RCC became aware of it two days later, upon returning to work. The RCC indicated he/she spoke with RPN #148 regarding the note on an identified date, and further indicated, because the incident was not witnessed, it was not reported to the Ministry of Health and Long-Term Care or Police. In addition, RCC #125 indicated he/she would only report suspected incident of abuse if it was a repeated pattern or intent to injure; and further indicated because both residents have cognitive impairments, they decided the incidents were not reportable. The RCC indicated he/she spoke to RPN #148, regarding the incident, and indicated a BSO referral was not completed, until three days later.

RCC #125 indicated not being aware of the three incidents that occurred on two identified dates over a two month period, involving resident #029. The RCC further indicated he/she was notified of the incident that occurred on an another identified date, by RN #150, as the RN emailed the RCC regarding the incident, and indicated no further action was taken as the BSO team was already involved. The RCC indicated being aware of another incident that occurred on another identified date,

because RPN #148 contacted him/her about the incident, but did not take any further action, as again, the BSO team was already involved. The RCC also indicated they discussed closer monitoring, and staff to be aware of whereabouts of resident #029.

On an identified date, interview with the BSO RPN #126 by Inspector #111, indicated resident #028, #029, #053, #054, #055, #056, #057, #058 #059 and #060 were all cognitively impaired and resident #029 was currently being monitored in the BSO program. The RPN further indicated interventions related to resident #029's behaviours were identified in the resident's plan of care and was provided to staff, located in a specific area.

RPN #126 indicated resident #029 also had a Dementia Observation System (DOS) completed, along with a referral for consultation. The home was unable to provide a copy of the consultation report. Review of the DOS for resident #029 indicated it was completed for five days within a specified period, and the resident was not being monitored every half hour.

On an identified date, interview of RN #133 by Inspector #111, indicated the RN completes the PIECES assessments or BAT tools, and will also start a DOS assessment before completing a referral to the BSO team. The RN indicated they do not always get BSO team involved with residents behaviours, until they can identify the resident's triggers and behaviours and possible strategies first.

On an identified date, interview with RN #153 by Inspector #111, indicated no awareness of being notified of the incidents that occurred on three identified dates, over a two month period, and indicated this would have been documented in resident #029's Progress Notes.

On an identified date, interview with the Director of Care (DOC) by Inspector #111, indicated not being aware of the incidents of resident to resident abuse, between resident #028 and resident #029, and on another identified date, between resident #029 and resident #057, as well as, the incidents of abuse that occurred on six identified dates over a four month period. Thus, no investigations were completed regarding the incidents.

A Compliance Order was warranted due to the scope and severity of identified incidents. There were several incidents of resident to resident responsive behaviours and potentially harmful the residents trigger. The altercations or interventions

involving resident #030 were not identified and implemented until five to ten days after an identified incident. The
interventions were also not implemented after the last incident, and the written plan of care was not updated to reflect the assessment (BAT) completed, as well as, there were several incidents of resident to resident responsive behaviours and potentially harmful interactions involving resident #029 and other residents, three resulting in injury. [s. 54. (a)]

(111)

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

Nov 20, 2017(A2)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure the plan of care is reviewed and revised, to ensure the planned care sets out clear directions to staff and others who provide direct care to the residents, specifically related to resident #010 and #017 regarding the use of restraint and or Personal Assistance Service Device (PASD) as well as resident #037, related to fall prevention devices.

The licensee shall review and revise the plan of care for all residents with PASDs, restraints and fall prevention devices needs within the home, to ensure that their plan of care sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of restraint, Personal Assistance Service Device (PASD) and a fall prevention device.

Observation of resident #010 on an identified date, indicated the resident was seated in a mobility aid with a restraint in place.

On an identified date, interview with Personal Support Worker (PSW) #104, indicated resident #010 use the device when using the mobility aid as a restraint for safety due to high risk for falls. The PSW indicated the mobility aid was only used as PASD for positioning and or comfort. The PSW was unaware of the frequency of repositioning of the mobility aid.

On an identified date, interview with Physiotherapist (PT) by Inspector #111, indicated resident #010 uses the mobility aid for positioning and comfort.

Review of the current written care plan for resident #010, indicated the resident had several interventions in place related to restraints and the use of the mobility aid.

The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of restraint and or Personal Assistance Service Device (PASD), the plan of care was unclear as to whether the mobility aid was a restraint and or a PASD. The plan of care was unclear as to which mobility aid was currently in use, and the PSW was unaware of the frequency of repositioning of the mobility aid. [s. 6. (1) (c)]

2. On an identified date and time, resident #017 was observed by Inspector #571 using a mobility aid with a restraint device in place. On another identified date and time, resident #017 was observed by Inspector #111, with the same mobility aid and restraint device in place.

Review of the Progress Notes for resident #017, indicated the resident was assessed by the Occupational Therapist (OT) and the Physiotherapist (PT) on four different occasions to identify risk related to the resident position in the mobility aid. The PT and the OT identified risks, made several recommendations and put in place interventions related to proper positioning of resident #017's mobility aid, in consultation with the residents family.

Review of current written plan of care for resident #017, indicated there several interventions in place in relation to the mobility aid, as well as the a restraint device.

On an identified date, interview with Personal Support Worker (PSW) #106 by Inspector #111, indicated resident #017 use the restraint device when using the mobility aid. The PSW indicated the resident's mobility aid has to be positioned to aid with the residents movement and posture.

On an identified date, interview with a Registered Practical Nurse (RPN) by Inspector #111, indicated resident #017 use the restraint device, when using the mobility aid, and further indicated the restraint device was a PASD for positioning.

On an identified date, interview with Physiotherapist (PT) by Inspector #111, indicated resident #017 use the mobility aid for position and safety due to near miss falls. The PT indicated the Occupational Therapist (OT) who completed the assessments at the time, was no longer working at the home.

The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of restraint device, as there was no clear directions provided to staff regarding the use of the mobility aid as a restraint, which was put in place for safety and to restrict the residents movements. There was no clear direction related to how and or when the mobility aid was to be used as per the instructions by the OT. [s. 6. (1) (c)]

3. Related to Log #032758-16 involving resident #037:

A Critical Incident Report was submitted to the Director on an identified date, for an incident for which resident #037 sustained an injury and was taken to hospital.

On an identified date and time, a symbol/logo signage indicated that the resident uses two fall prevention devices.

Review of the current plan of care for resident #037 indicated, that the resident was at high risk for falls related to an unsteady gait and had four fall prevention interventions in place.

On an identified date, in an interview, Personal Support Worker (PSW) #141 and Registered Practical Nurse (RPN) #129, both indicated to the Inspector that resident #037 no longer uses the fall prevention devices, as the resident now uses a mobility aid, and did not have a fall since an identified incident.

On an identified date, interview the Resident Care Coordinator (RCC) #125 indicated, the home's expectation is that the written care plan is to be updated by the registered staff. The RCC #125 further indicated, that resident #037's care plan did not provide clear directions to staff, as the fall prevention devices, were no longer being used.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #037, as the logo/symbol on the communication board, indicated the resident uses fall prevention devices, when these devices were no longer in use. [s. 6. (1) (c)] (607)

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

Sep 30, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 8 day of September 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JULIET MANDERSON-GRAY - (A2)

Service Area Office /
Bureau régional de services : Ottawa