Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 18, 2018	2018_689586_0012	002732-18	Resident Quality Inspection

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Faith Manor Nursing Home
7900 Mclaughlin Road South BRAMPTON ON L6Y 5A7

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

JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 22 and 23, 2018.

APRIL TOLENTINO (218), DARIA TRZOS (561), HEATHER PRESTON (640), KELLY HAYES (583).

The RQI Inspection Report and Order Report were served to the home on March 21, 2018.

The following Critical Incident System (CIS) Inspection was conducted concurrently with the RQI:
029263-16 - Prevention of Abuse & Neglect;
009735-16 - Prevention of Abuse & Neglect;
011126-17 - Medication Management;
011129-17 - Medication Management;
011274-17 - Medication Management;
022784-17 - Skin & Wound Management;
001366-18 - Personal Support Services;
003373-18 - Prevention of Abuse & Neglect; and,
003919-18 - Prevention of Abuse & Neglect.

The following Complaint Inspection was conducted concurrently with the RQI:
022705-17 - Skin & Wound Management.

The following On-site Inquiries were conducted concurrently with the RQI:
024678-17 - Medication Management;
028490-17 - Prevention of Abuse & Neglect;
020787-17 - Prevention of Abuse & Neglect;
021800-17 - Personal Support Services;
029592-17 - Prevention of Abuse & Neglect; and,
000021-18 - Prevention of Abuse & Neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Nursing Supervisor, Resident Assessment Instrument (RAI) Co-ordinator, Behavioural Support Lead (BSL), Education Co-ordinator, Registered Dietitian (RD), Staff Scheduler, Restorative Care Nurse, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services and reviewed relevant documents including but not limited to clinical health care records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **12 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out the planned care for the resident.

Resident #006 sustained a fall on an identified date in 2017 resulting in injury. Registered staff implemented a new intervention to prevent future falls. The written plan of care was reviewed and did not include this intervention. The Falls Lead/Nursing Supervisor indicated that it was either the registered staff, the RAI Coordinator or the Falls Lead's responsibility to update the written plans of care depending on who was the person completing an assessment that required updates in the written plan of care. The DOC confirmed that the written plan of care should have reflected the care required for residents and that it should have been updated as soon as possible with any new interventions. The licensee failed to ensure that the written plan of care set out the planned care for resident #006 related to the falls interventions. (561) [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident. Resident #006 sustained a fall on an

identified date in 2017 resulting in injury. When the resident returned to the home they had a significant change and the MDS significant change assessment was completed. The Resident Assessment Protocol (RAP) indicated
that resident was at risk for falls and their locomotion changed, as well as other activities of daily living (ADL).

The written plan of care was reviewed and updated after the fall and did not provide clear direction to staff related to the multiple interventions for falls. RPN #107 was interviewed and indicated that the RAI Coordinator was the person who was responsible for updating the written plans of care. The Falls Lead/Nursing Supervisor indicated that it was either the registered staff, the RAI Coordinator or the
Falls Lead's responsibility to update the written plans of care depending on who was the person completing an assessment that required updates in the written plan of care. The DOC confirmed that the written plan of care should reflect the care required for residents and that it should be updated as soon as possible with any new interventions. The licensee failed to ensure that the written plan of care provided clear direction to staff in relation to the falls interventions. (561) [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #006 was assessed to be at risk for fall on admission. The written plan of care was reviewed and was not consistent with the Falls Risk Assessment or the RAP completed, indicating that the resident was at an alternative risk level for falls. RPN #107 confirmed that the written plan of care was not consistent with the Falls Risk Assessment and the RAP. The RPN indicated that the care plans were being updated by the RAI Coordinator, whereas the Falls Risk Assessment was being completed by registered staff. The Falls Lead and the DOC both confirmed that the written plan of care should reflect the Falls Risk Assessments. The home failed to ensure that the staff collaborated with each other in the assessment of the resident and that the written plan of care was consistent with the RAP and the Falls Risk Assessment. (561) [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001's documented plan of care, which front line staff used to direct care, indicated that the resident required a certain level of assistance for all aspects of care.

On an identified date in 2018, PSW #120 was providing care to resident #001 when the resident fell. The resident was diagnosed with a significant injury.

According to the home's internal investigation notes, and in an interview wit PSW #120, the PSW indicated that the resident was at risk of this due to certain behaviours they exhibited. RPN #125 indicated that the incident likely happened because the resident required a certain level of assistance for care, which they did not receive at that time. The PSW confirmed with the LTC Inspector that they were providing care to the resident independently. They indicated that they were unaware that the resident required a different level of assistance for care at the time, and acknowledged that they did not follow the resident's plan of care.

As documented in the home's internal investigation notes, and through interview with the DRC, they acknowledged that resident #001 was not provided with care as documented in the plan of care which resulted in significant injury. (586) [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 the resident was protected from abuse by anyone.

A) Ontario Regulations 79/10 defined 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)(c).

A review of documentation in resident #020 and #021's clinical records indicated the following:

On February 11, 2018, RPN #126 went into resident #021's room to administer a scheduled medication at 2300 hours. In an interview with RPN #126 on February 22, 2018, they confirmed at the same time resident #021 did ring the call bell for help. At that time resident #021 shared that they had been punched multiple times in the face by their roommate, resident #020, while in bed. It was identified that resident #020's physical responsive behaviour was initially triggered by resident #021 turning their bedside light on above their bed. Resident #020 confirmed that they hit resident #021 and that they were upset about resident #021's light being on.

Resident #020 alleged that resident #021 kicked them when they tried to turn their roommate's light off but resident #021 denied this occurred. In an interview with resident #021 on February 20, 2018, they shared they did not kick resident #020 when the resident approached them and there was no verbal interaction about the light prior to being struck by resident #021 on February 11, 2018.

As a result of the altercation, resident #020 sustained a 5 by 6.5 centimetre bruise to their right forearm. Resident #021 sustained a scratch to left side of chin, a large subconjunctival hemorrhage to the left eye with mild orbital swelling and bruising. Resident #021 reported loss in vision and a change from their baseline. As per the physician and NP assessments, it was difficult to distinguish between the resident's baseline visual function and acute findings. Resident #021 was sent out to an ophthalmology eye clinic at urgent care for further assessment where it was determined that there was no internal ocular injury of the left eye. After the altercation resident #021 expressed feelings of fear and anxiousness.

It was noted at the time of the incident that residents #020 and #021 were not new residents to the home but newly residing in the same room with each other for four days. Resident #020 did not have a history of any known responsive behaviours, had short term memory loss and dementia. Resident #021 was identified to have a moderate deficit in memory, judgement, decision making and thought processes related to Alzheimer's disease and dementia. Resident #021's care plan at the time of the incident identified that the resident would argue with roommates, strike out at others when disturbed related to personal space. The care plan intervention directed the resident to ask staff for assistance, to redirect others when feeling annoyed or disturbed and encourage the resident not to argue or strike out at others.

In an interview with the BSL on February 21, 2018, it was confirmed that resident #021 had demonstrated verbal and physical responsive behaviours towards a previous roommate in July 2017, requiring a resident room change. It was identified during interviews with staff that resident #021 had not demonstrated responsive behaviours recently but that it was unpredictable when
they may occur and that the resident was very territorial of their space.

In an interview with the DRC on February 22, 2018, it was confirmed that resident #020 was not protected from physical abuse by resident #021. (583).

B) The home's definition of physical abuse outlined in the, "Zero Tolerance of Resident Abuse & Neglect" policy (dated December 8, 2017) also defined physical abuse as stated above.

A CIS report #2745-000023-17 submitted to the Ministry of Health and Long-Term Care (MOHLTC) described an incident of resident-to-resident physical abuse that occurred on May 17, 2017, at 2340 hours. The report documented that resident #017 entered resident #016's bedroom and pushed resident #016, causing them to fall and be sent to the hospital. Resident #016 sustained a
fractured left shoulder as a result of this incident.

Clinical record reviews showed that resident #017 had a Cognitive Performance Score (CPS) of five out of six and resident #016 was classified as a three out of six. Both residents resided on the second floor of the home at the time of the incident.

A review of the documented plan of care for resident #016 showed that they exhibited anxious/agitated behaviours and disliked wanderers entering their room. Resident #016 could yell and/or strike out at staff/others when upset or being redirected. Interventions to address these behaviours at the time of the incident were documented as follows:
- A door alarm in place to alert staff of wandering residents attempting to enter their room;
- Staff to keep the bedroom door closed to prevent alarm from going off;
- Monitor resident's whereabouts periodically to ensure safety;
- Staff to ensure wander guard was in place to deter wandering residents; and,
- Encourage resident to ask staff and/or use call bell to assist with redirecting others.

A review of the documented plan of care for resident #017 showed that they exhibited

and enter others' rooms, sleep on their beds, and take their belongings. Resident #017 was placed on a 15-minute check and this was documented by staff on the day of the incident. The documented care plan indicated that staff were to allow resident #017 to wander safely on the unit, redirect them away from exit doors and provide assistance in locating their own room or other areas on the unit as needed.

A review of the progress notes dated May 17, 2017, at 2340 hours documented that resident #016 was found by a PSW in their bedroom sitting on the floor in the dark holding their left arm. Resident #017 was seen exiting resident #016's bedroom. Resident #016 stated, "a guy came into my room, took my shoes and pushed me".

Resident #016 was interviewed on February 14, 2018, and they were able to recall the incident. Resident #016 stated that a co-resident had pushed them resulting in an injury to their arm. Resident #016 stated that this made them want to leave the home.

During staff interviews, the BSL and DRC stated that the expectation was for the above interventions to have been in place at the time of the incident. The BSL stated that they specifically considered the door alarm an effective intervention because it would alert staff immediately when somebody entered the room. The BSL also stated that there was no formal documentation completed by staff to monitor and determine the resident #016's whereabouts as noted in their care plan.

During a staff interview conducted with PSW #115 and RN #113, they both stated that the door alarm was not in place at the time of the incident. RN #113 stated that this was an old intervention. RN #113 stated that they could not verify if the resident's wander guard was in place at the time of the incident but that resident #017 could have removed this intervention anyway. RN #113 said that they became aware of the incident because a former PSW heard resident #016 was yelling for help in their bedroom.

During a staff interview, DRC #108 stated the outcome of their investigation concluded that resident #016 was physically harmed by resident #017. DRC #108 stated that they were not familiar that a door alarm was utilized as an intervention in the home. The DRC acknowledged that the interventions outlined in resident #016's plan of care were not in place at the time of the incident. DRC #108 acknowledged that the interventions could have protected resident #016 from physical abuse by resident #017.

The licensee failed to protect resident #016 from abuse by co-resident #017 resulting in physical harm. (218).

C) Ontario Regulations 79/10 defined emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident" O. Reg. 79/10, s. 2 (1)(a).

The home's definition of emotional abuse outlined in the, "Zero Tolerance of Resident Abuse & Neglect" policy (dated December 8, 2017) also defined emotional abuse as stated above.

During the course of the RQI, an incident related to staff-to-resident abuse was identified. On the evening of February 7, 2018, a PSW #118 was assisting resident #008 during their shower and provided them with care that was perceived as "rough".

A record review of the resident #008's documented plan of care indicated that they required one staff member to provide some physical assistance during their bath and one person to provide intermittent supervision and assistance with their hygiene and dressing tasks. Resident #008??s CPS was classified as a two out of six, indicating low cognitive impairment.

During an interview conducted with resident #008, they shared that PSW #118 assisted them with their shower on the evening of February 7, 2018. Resident #008 alleged that PSW #118 washed their private area roughly without obtaining their consent. Resident #008 stated that they usually performed this task independently but PSW #118 took control and proceeded to provide care "roughly". Resident #008 stated that the incident made them feel distressed and belittled. Resident #008 stated that RPN #107 was immediately notified of the incident.

During an interview conducted with PSW #118, they acknowledged that they provided assistance to resident #008 during their shower on February 7, 2018. PSW #118 stated that they provided care "quick and fast" PSW #118 stated that RPN #107 witnessed the later part of the incident.

During an interview conducted with RPN #107, they stated that they were informed of the incident by resident #008 and PSW #118. RPN #107 stated that resident #008 appeared emotionally distraught as a result of the incident. RPN #107 stated that they considered the incident to be abuse.

A review of the LTCH's investigation notes concluded that abuse occurred. During an interview, the Administrator stated that they considered "rough care" to be a form of abuse and that the home had zero tolerance for this type of approach. As a result of the incident, a disciplinary letter was issued to PSW #118 on February 22, 2018, for abuse towards resident #008.

The licensee failed to protect resident #008 from abuse by a staff member during the provision of care that resulted in a negative emotional impact. (218).

D) During the above internal investigation, resident #027 was also interviewed about the care they had received in the past from PSW #118. The resident voiced concern to the DRC that PSW #118 was rough with them during care on February 7, 2018. This was documented in the home's internal investigation notes. In an interview with the resident on February 22, 2018, the resident expressed to the LTC Inspector that the incident with the PSW made them feel upset and anxious. During an interview with LTC Inspector #218 on February 21, 2018, with the Administrator, and on February 22, 2018, with the DRC, both confirmed that resident #027 was not protected from emotional abuse by PSW #118. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A CIS report submitted to the MOHLTC described an incident of resident to resident physical abuse that occurred on an identified date in 2017. The outcome of the home's investigation concluded that resident #017 assaulted resident #016 resulting in physical harm.

A review of the home's policy, "Zero Tolerance of Resident Abuse & Neglect" (dated December 8, 2017) stipulated that an investigation would be conducted immediately for every report of alleged, suspected or witnessed incident of abuse and neglect.

Furthermore, the policy provided direction for the Charge Nurse or DRC to assist any person in completing a "Resident Abuse & Neglect - Incident Reporting Form" as part of the investigation records.

During an interview, DRC #108 stated that they were not familiar with completing the required incident form as noted in the policy. The DRC stated that they had not interviewed resident #016 and relied on the staff's feedback and documentation related to the incident. DRC #108 stated that they had no documented records of the interviews undertaken with the staff members involved. The DRC acknowledged that the Incident Reporting Form was not utilized as required by the home's policy.

B) During the course of the RQI, an incident of abuse was identified to have occurred on an identified date in 2018, by PSW #118 towards resident #008 during care. RPN #107 was immediately notified by resident #008 and PSW #118 after the incident occurred. During an interview conducted with the DRC, they stated that for all abuse related incidents, registered staff are responsible for completing a head-to-toe assessment and for documenting an incident report under the 'Risk Management' tab on PCC.

A review of the home's policy, "Zero Tolerance of Resident Abuse & Neglect" (dated December 8, 2017) stipulated that following an examination of the allegedly abused resident, the nurse in consultation with the DRC would determine if the resident required medical attention. Recommendations would then be documented and implemented in the resident's plan of care. During an interview conducted with RPN #107, they verified that they were approached by resident #008 alleging that PSW #118 provided them with rough care. RPN #107 stated that resident #008 was emotionally distraught as a result of the incident. RPN #107 acknowledged that there was no documented records of the incident noted on PCC and that a physical assessment was not completed for resident #008 as required.

A record review of the home's electronic records on PCC showed no documentation related to the incident above. There was also no evidence to demonstrate that resident #008 was assessed or examined by staff after the incident occurred.

In an interview conducted with the DRC and Administrator, both stated that an assessment of the resident immediately following an abuse related incident should have been completed for resident #008 and documented.

The home did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents related to assessments and documentation was complied with. (218) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred should immediately report the information upon which it was based to the Director.

During the course of the RQI, an incident of abuse was identified to have occurred on an identified date in 2018, by PSW #118 towards resident #008 during care. During interviews, PSW #118 and resident #008 both stated that the RPN #107 was notified of the incident immediately after it had occurred.

A review of the LTCH's policy, "Zero Tolerance of Resident Abuse & Neglect" (dated December 8, 2017) documented that all staff must immediately report all suspected, alleged, witnessed or actual incidents of resident abuse to the DRC. If the incident occurred in the evening, such incidents were to be reported to the on-call Manager who must immediately notify the DRC or Administrator by telephone.

During an interview with RPN #107, they acknowledged that they were immediately informed by resident #008 and PSW #118 of the alleged incident after it had occurred. RPN #107 stated that they considered the incident to be a form of abuse toward resident #008. RPN #107 stated that resident #008 was emotionally distraught as a result of the incident. RPN #107 shared that they were not familiar with the legislative requirements related to Mandatory Reporting to the Director as per the Long-Term Care Homes Act.

RPN #107 stated that they did not know what the terminology meant. RPN #107 stated that the expectation was for them to notify Nursing Supervisor #119 of all abuse related incidents. RPN #107 stated that Nursing Supervisor #119 was immediately notified on the evening of the incident.

During an interview completed with Nursing Supervisor #119, they denied that they were informed of the incident of staff to resident abuse involving PSW #118 towards resident #008 that occurred on the identified date. Nursing Supervisor #119 clarified that they did not notify the DRC or the Director as required.

During an interview with the DRC, they stated that they were not informed by anyone of the abuse incident that occurred on the identified date. The DRC stated that the expectation would have been for either the RPN #107 or Nursing Supervisor #119 to have immediately reported the incident to the DRC so that an investigation could be initiated and reported to the Director immediately.

During an interview with the Administrator and DRC, they both acknowledged that the Director was not immediately informed of the incident that occurred on the identified date.

An internal investigation was completed and they determined that resident #008 was abused by PSW #118 during the provision of care.

The licensee failed to ensure that the Director was immediately notified of an incident where a resident was abused by a staff member. (218) [s. 24. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

A) A CIS report was submitted to the Director related to a missing controlled substance that occurred on an identified date in 2017. The medication incident report completed by the home was reviewed and indicated that the missing controlled substance was reported late.

The home's policy, "Reporting Medication Incidents" (policy number 7.3, revised July 2014) indicated that all incidents regardless of origin were to be communicated to Classic Care Pharmacy by providing a completed medication incident form. Upon discovery of a medication incident, the health and safety of the resident was the first priority, the resident's condition was to be assessed and immediate action taken if needed. The home then was to investigate the incident, and documentation completed and communicated with the pharmacy and report was to be filed. The home must report to the Director no later than one business day after the occurrence of the missing or unaccounted for controlled substance.

The clinical health records for resident #014 were reviewed and the home's Risk Management Check Sheet that was completed for medication incidents indicated that the missing controlled substance was noted to be missing on the identified date and that the registered staff did not report the incident until three days later. The DRC confirmed that the incident occurred was not reported to the Director until three days later.

B) Through the review of the clinical health records for resident #014 related to two missing controlled substances reported to the Director on identified dates in 2017, the LTC Inspector identified that there was a third incident of the controlled substance missing with the same resident that was never reported to the Director by the home. The registered staff along with two PSWs tried to look for the medication and were unable to locate it. The progress notes and interview with the DRC confirmed that the incident report was not completed and the CIS report was not submitted to the Director related to the third incident of the missing controlled substance. [s. 107. (3) 3.]

2. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's condition.

A) Resident #006 fell on an identified date in 2017 and sustained an injury. The resident returned to the home from an outside resource and required treatment as well as a change in ambulation. The clinical health records were reviewed and indicated that the home did not submit a CIS report to the Director.

B) Resident #006 fell on an identified date in 2017 and sustained an injury, requiring multiple changes to their plan of care. The clinical health records were reviewed and indicated that a CIS report was not submitted to the Director.

The home's policy, "Mandatory and Critical Incident Reporting" (policy number HR-00-12 -04, last revised May 9, 2017) indicated that a CIS report was to be completed when a resident sustained an injury resulting in transfer to hospital and where a significant change occurred to the resident's health condition.

In an interview, the DOC confirmed that the CIS's were not submitted for the two incidents and should have been as per the home's policy.

The home failed to ensure that they informed the Director of the two incidents that caused injuries to the resident for which they were taken to the hospital and resulted in a significant change in resident's condition. (561) [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance, to be implemented voluntarily, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Two CIS reports were submitted to the Director related to a missing controlled substance on two identified dates in 2017.

The health care records were reviewed during the RQI inspection. PSW #118 was interviewed by LTC Inspector and stated that they were not aware that this resident required the specified type of medication and believed that resident had a double dose of it. After this incident, the home provided re-training to the PSWs regarding this type of medication and their involvement in it. The DRC confirmed that the medical intervention was not to be removed by the PSWs and was to be administered as prescribed. (561) [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

On an identified date in 2018 it was identified by LTC Inspector #591 when they reviewed the emergency drug supply, that there was an error in documentation of the narcotics that were part of the emergency drug supply. Five ampules of 1 millilitre (mL) morphine sulphate 15 milligrams per millilitre (mg/mL) injections were found; however, the staff documented on the Narcotic Ward Count sheet that it was morphine sulphate 5 mg/mL.

Registered staff during count were signing for it as it was morphine 5 mg/mL. This issue was brought up with the home by LTC Inspector #591 on the same day.

On a later date during the inspection, LTC Inspector #561 asked the home what actions

were taken in relation to the issue identified and the DRC confirmed that the issue was corrected. The DRC went with the LTC Inspector to the medication room to check the correction. RPN #114 was interviewed and indicated that they had corrected the Narcotic Ward Count sheet. LTC Inspector #561 reviewed the information and checked the ampules again and identified that the error was not fully corrected. The label on the container which held each ampule had a pharmacy label indicating that it was 10mL morphine sulphate 15 mg/mL. Registered staff crossed out 10 mL with a pen and wrote 1 mL beside it on each container after the error was first identified by the LTC Inspector.

The DOC then indicated that this was a pharmacy error and an incident report should have been completed. The DOC then asked the registered staff to immediately remove the ampules from the emergency box supply, re-order new ampules and notify the pharmacy of the error.

The home's policy, "Reporting Medication Incidents" (policy number 7.3, revised July 2014) indicated that all incidents regardless of origin were to be communicated to Classic Care Pharmacy by providing a completed medication incident form.

The home failed to ensure that every medication incident was documented together with a record of the immediate actions taken. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The LTC Inspector #640 reviewed the medication incidents for 2017 as provided by the DRC which included nine medication incidences. The Medical/Pharmacy Advisory Committee meeting dated June 2, 2017, did not review any medication incidents. The Medical/Pharmacy Advisory Committee meeting dated December 15, 2017, reviewed three medication incidents of omission.

During an interview with the DRC, they acknowledged that the medication incidents were not reviewed as required for the three quarterly Medical/Pharmacy Advisory Committee meetings.(561) [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to have his or her personal health information kept within the meaning of the Personal Health Information Protection Act, 2014 and kept confidential in accordance with that Act, including his or her plan of care, in accordance with that Act.

In an interview with the Nursing Supervisor/Falls Lead, they indicated that they tracked all the falls in the home and kept an electronic spreadsheet tool to look for trends. The tracking tool contained residents' names, dates of the falls, times of the falls, location of the falls, whether injuries was sustained, whether residents were sent to the hospital, and whether the care plans was reviewed. The LTC Inspector requested to see the tool for the months of August, October and November 2017. The Nursing Supervisor/Falls Lead was not able to find the spreadsheets and stated that they were on their laptop which was at their home. The LTC Inspector told the Nursing Supervisor/Falls Lead that they could bring the tool the next day. Later that day the Nursing Supervisor/Falls Lead brought copies of the tracking tool and indicated that they had asked their family member to access their laptop at home and forward the spreadsheet via email. The Nursing Supervisor/Falls Lead failed to ensure that the personal health records of residents were kept confidential in accordance with the Act. The DRC was informed by the LTC Inspector and indicated that this was not acceptable.

The home failed to ensure that every resident had the right to have their personal health information kept within the meaning of the PHIPA. [s. 3. (1) 11. iv.] (561) [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) In accordance with O. Reg. 79/10, s.48, the licensee shall to ensure that the interdisciplinary programs including the falls prevention and management program, were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

The home's program, "Falls Prevention and Management Program" (revised April 7, 2017) indicated that a HCH Post Fall - Resident Case Study Review Assessment was to be completed when resident had 3 or more falls in a period of 30 days and/or if there was a significant change in resident's condition such as significant injury resulting from a fall.

The Holland Christian Homes Post Fall - Resident Case Study Review Assessment was an assessment that was completed by a multidisciplinary team to assess each resident individually in order to review prior falls and review strategies to reduce the incidence of falls.

i. Resident #006 sustained multiple documented falls in one identified month in 2017, in which one of them resulted in an injury. The resident sustained multiple falls in another month in 2017, one resulting in injury. The review of the clinical health record indicated that the HCH Post Fall - Resident Case Study Review Assessments were not completed after any of those falls.

ii. Resident #022 sustained multiple documented falls in one identified month in 2017. The clinical record review indicated that the HCH Post Fall - Resident Case Study Review Assessment was not completed after these falls.

iii. Resident #023 sustained multiple documented falls in one identified month in 2017 and multiple in another month. The clinical record review indicated that the HCH Post Fall - Resident Case Study Review Assessments were not completed after these falls.

The Falls Lead/Nursing Supervisor was interviewed and indicated that the HCH Post Fall - Resident Case Study Review Assessment was to be completed after a resident sustained three falls in a period of 30 days and confirmed that this was not done for the

resident #006.

The DRC confirmed that the HCH Post Fall - Resident Case Study Review Assessment should have been completed for the resident after the falls.

The home failed to ensure that the home's Falls Prevention and Management Program was complied with.

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

The Ontario Regulation 79/10 of the Long Term Care Homes Act, 2007, regulation 136(4) indicates that the licensee is required to ensure that where a drug is to be destroyed and is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:
1. The date of removal of the drug from the drug storage area
2. The name of the resident for whom the drug was prescribed, where applicable
3. The prescription number of the drug, where applicable
4. The drug's name, strength and quantity
5. The reason for destruction
6. The date when the drug was destroyed
7. The names of the persons who destroyed the drug
8. The manner of destruction of the drug

The home's policy, "Medication Disposal - Controlled Substances/LTCH's" (policy number 5.8.1, revised July 2014) indicated that for all controlled substances that were to be destroyed, the following information must be documented: the name of the resident for whom the drug was prescribed, the drug's name, strength and dosage form, prescription number of the drug and the date drug was dispensed, the reason for destruction, the names of persons who destroyed the drug and the manner of destruction. The registered staff and the pharmacist sign and date the form. The resident's individual count sheet was to be photocopied and filed and retained by the DRC in the home for a period of no less than two years as part of the drug record.

The home's policy, "LTC FentaNYL Patch Secure Disposal Form" (policy number 5.8.4, revised October 2016) indicated that the Fentanyl patch once removed from the resident needed to be affixed into a form and secured with tape, two registered staff sign the form and date it and place in the narcotic bin.

The DRC was interviewed and confirmed process of drug destruction and the specific destruction of the medication. A CIS was submitted to the Director on an identified date in 2017, related to a missing
controlled substance that was administered to resident #013. The medication incident report completed by the home was reviewed and indicated that resident had a specific medication order; however, there were forty-two days between the last administration of the drug and the date the physician discontinued the order, and there was no record of the count of the medication that was administered in that time.
The clinical health records were reviewed during the RQI inspection. Resident #014 had a physician's order for a specific medication; however, there were five days between the last administration of the drug and the date the physician discontinued the order, and there was no record of the count of the medication that was administered in that time.

Interviewed the registered staff #100 and confirmed the above process for the medication destruction as indicated in the home's policy.

Both resident's charts were reviewed and there was no information found of how the medications were destroyed, there was no documentation indicating on which dates the discontinued remaining medications were removed from the medication cart and no forms could be found that would indicate the proper removal and destruction of the medications.

The DRC was interviewed and indicated that there was a process in place to dispose of the medications in the home and documentation was provided of the education given to staff on proper disposal of the medications. The DRC could not find the documentation that would show that medications were properly removed and disposed of in the home.

The DRC confirmed that the documentation of the disposal as indicated in the policy, "Medication Disposal - Controlled Substances/LTCH's" should have been kept in the home. (561) [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents of the home were bathed, at a minimum, twice a week by the method of his or her choice.

During an interview with resident #009, they told the LTC Inspector of their bathing preference and said they had not been given that preference since admission.

The LTC Inspector reviewed the resident's written plan of care and found the preference that they had mentioned was included. Review of the bath schedule identified the method of choice was not included but the shift and day of the week were. During a review of the resident's clinical record, a document titled, 'New Admission FM1 & FM2' was located which had their identified preference clearly circled as the bathing preference.

During an interview of PSW #102, they told the LTC Inspector that resident #009 was given the alternative on their bath day. They showed the LTC Inspector where the information was for the PSWs to know the resident's bathing preference. The PSW reviewed the contents of the written plan of care and noted the preference for resident #009 was for their identified preference and not the alternative.

The home's policy, "Bathing and Personal Hygiene" (policy number 03, revised June 11, 2017) directed staff to bathe each resident at a minimum of twice a week by the method of his or her choice.

During an interview with the DRC, they stated that it was expected the resident to have received the bath of choice at a minimum, since the installation of the new bathtubs. Resident #009 was not bathed by the method of their choice. (640). [s. 33. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

s. 115. (2) Where the pharmacy service provider is a corporation, the licensee shall ensure that a pharmacist from the pharmacy service provider participates in the quarterly evaluation. O. Reg. 79/10, s. 115 (2).

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The meeting minutes of the quarterly review of the medication management system were reviewed by LTC Inspector #640.

i. During a review of quarterly review of the medication management system held June 2, 2017, there were no inclusions in the minutes related to the medication management system.

ii. The written record of the quarterly reviews of the medication management system held June 2 and September 15, 2017, did not include any recommended changes necessary to improve the system.

During an interview with the DRC, they acknowledged the June 2, 2017, meeting did not include any medication management system reviews and the meetings held on June 2 and September 15, 2017, did not include any recommended changes necessary to improve the system. [s. 115. (1)]

2. The licensee has failed to ensure the quarterly evaluation of the medication management system included a review of the drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs that could potentially place residents at risk.

During review of Medical/Pharmacy Advisory Committee Meeting minutes by LTC Inspector #640, from June 2, 2017, September 15 and December 15, 2017, the written record did not include drug utilizations and drug utilization patterns in the home including the use of any drug or combination of drugs, including psychotropic drugs.

During an interview with the DRC, they acknowledged the quarterly evaluations of the medication management program for June 2, 2017, September 15, 2017 and December 15, 2017, did not include drug utilizations and drug utilization patterns in the home including the use of any drug or combination of drugs, including psychotropic drugs. (561) [s. 115. (3)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year.

During a review of the Medication Management System annual evaluation document by LTC Inspector #640, dated June 2, 2017, as provided by the DRC, there was no documentation that all quarterly reviews from the previous year were reviewed. During an interview with the DRC, they acknowledged the previous quarterly evaluations of the medication management program were not reviewed as part of the annual evaluation of the system. (561) [s. 116. (3)]

Issued on this 18th day of April, 2018

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

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

Ministére 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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586)
Inspection No. / No de l'inspection :	2018_689586_0012
Log No. / No de registre :	002732-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 18, 2018
Licensee / Titulaire de permis :	Holland Christian Homes Inc. 7900 McLaughlin Road South, BRAMPTON, ON, L6Y-5A7
LTC Home / Foyer de SLD :	Faith Manor Nursing Home 7900 Mclaughlin Road South, BRAMPTON, ON, L6Y-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Kamino

To Holland Christian Homes Inc., 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

The licensee shall ensure that the care set out in resident #001's plan of care in relation to the level of assistance provided during care is provided to the resident as specified in the plan.

The licensee shall provide education to PSW staff #120 on the policies and procedures related to resident plans of care and falls prevention and management. There shall be a record of the training provided to the employee. This record shall include the date that the training was completed, topics covered and who/how the training was completed.

Grounds / Motifs :

1. The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 1 as it related to one resident reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
-compliance order (CO) #001 issued July 19, 2016 with a compliance due date of October 28, 2016 (2016_265526_0010);
-compliance order (CO) #003 issued May 23, 2017 with a compliance due date of May 31, 2017 (2017_544527_0003).

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

Resident #001's documented plan of care, which front line staff used to direct care, indicated that the resident required a certain level of assistance for all aspects of care.

On an identified date in 2018, PSW #120 was providing care to resident #001 when the resident fell. The resident was diagnosed with a significant injury.

According to the home's internal investigation notes, and in an interview wit PSW #120, the PSW indicated that the resident was at risk of this due to certain behaviours they exhibited. RPN #125 indicated that the incident likely happened because the resident required a certain level of assistance for care, which they did not receive at that time. The PSW confirmed with the LTC Inspector that they were providing care to the resident independently. They indicated that they were unaware that the resident required a different level of assistance for care at the time, and acknowledged that they did not follow the resident's plan of care.

As documented in the home's internal investigation notes, and through interview with the DRC, they acknowledged that resident #001 was not provided with care as documented in the plan of care which resulted in significant injury. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 23, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

The licensee shall ensure that residents #016 and #020 are protected from physical abuse by a co-resident, and residents #008 and #027 are protected from emotional abuse by staff.

The licensee shall review the plans of care for residents #017 and #021 and revise, as necessary, the plans to ensure that all triggers are identified and possible interventions are put into place to mitigate and manage those behaviours and to ensure the safety of co-residents.

The licensee shall provide education to PSW staff #118 on resident abuse before the completion of their next scheduled shift. There shall be a record of the training provided to the employee. This record shall include the date that the training was completed, topics covered and who/how the training was completed.

Grounds / Motifs :

1. The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to four of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:
• voluntary plan of correction (VPC) issued March 30, 2016 (2016_449619_0008);
• compliance order (CO) #002 issued July 19, 2016 with a compliance due date of October 28, 2016 (2016_265526_0010);

The licensee has failed to ensure that the resident was protected from abuse by anyone.

A) Ontario Regulations 79/10 defined 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)(c).

A review of documentation in resident #020 and #021's clinical records indicated the following:

On an identified date in 2018, RPN #126 went into resident #021's room to administer a scheduled medication. In an interview with RPN #126, they confirmed at the same time resident #021 did ring the call bell for help. At that time resident #021 shared that they had been assaulted by their roommate, resident #020. It was identified that resident #020's physical responsive behaviour was initially triggered by a specific action resident #021 did.

In an interview with resident #021, they denied that this occurred.

As a result of the altercation, both residents sustained injuries. After the altercation resident #021 expressed feelings of fear and anxiousness.

It was noted at the time of the incident that residents #020 and #021 were not new residents to the home but newly residing in the same room with each other. Resident #020 did not have a history of any known responsive behaviours. Resident #021's care plan at the time of the incident identified triggers resulting in aggression, and included interventions to mitigate this risk.

In an interview with the BSL, it was confirmed that resident #021 had demonstrated verbal and physical responsive behaviours towards a previous roommate in the past, requiring a resident room change. It was identified during interviews with staff that resident #021 had not demonstrated responsive behaviours recently but that it was unpredictable when they may occur.

In an interview with the DRC, it was confirmed that resident #020 was not protected from physical abuse by resident #021. (583).

B) The home's definition of physical abuse outlined in the, "Zero Tolerance of Resident Abuse & Neglect" policy (dated December 8, 2017) also defined

physical abuse as stated above.

A CIS report #2745-000023-17 submitted to the Ministry of Health and Long-Term Care (MOHLTC) described an incident of resident-to-resident physical abuse that occurred on an identified date in 2017. The report documented that resident #017 assaulted resident #016, causing injury.

A review of the documented plan of care for resident's #016 and #017 showed that they exhibited certain responsive behaviours and listed interventions to mitigate these risks.

A review of the progress notes documented that resident #016 was found by a PSW with an injury while resident #017 was exiting the area. Resident #016 indicated that someone had hurt them.

Resident #016 was interviewed and they were able to recall the incident. Resident #016 stated that a co-resident had injured them and that they were upset by this occurrence.

During staff interviews, the BSL and DRC stated that the expectation was for the specific interventions listed in the plans of care to have been in place at the time of the incident. The BSL stated that they specifically considered an identified intervention tool as an effective intervention because it would alert staff immediately when somebody entered the room. The BSL also stated that there was no formal documentation completed by staff to monitor and determine the resident #016's whereabouts as noted in their care plan.

During a staff interview conducted with PSW #115 and RN #113, they both stated that the identified intervention tool was not in place at the time of the incident. RN #113 stated that this was an old intervention. RN #113 stated that they could not verify if one of the other intervention tools for the resident was in place at the time of the incident but that resident #017 could have removed this intervention anyway. RN #113 said that they became aware of the incident because a former PSW heard resident #016 requesting for help.

During a staff interview, DRC #108 stated the outcome of their investigation concluded that resident #016 was physically harmed by resident #017. DRC #108 stated that they were not familiar that an identified intervention tool was utilized as an intervention in the home.

The DRC acknowledged that the interventions outlined in resident #016's plan of care were not in place at the time of the incident. DRC #108 acknowledged that the interventions could have protected resident #016 from physical abuse by resident #017.

The licensee failed to protect resident #016 from abuse by co-resident #017 resulting in physical harm. (218).

C) Ontario Regulations 79/10 defined emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident" O. Reg. 79/10, s. 2 (1)(a).

The home's definition of emotional abuse outlined in the, "Zero Tolerance of Resident Abuse & Neglect" policy (dated December 8, 2017) also defined emotional abuse as stated above.

During the course of the RQI, an incident related to staff-to-resident abuse was identified. On an identified date in 2018, a PSW #118 was assisting resident #008 during care and the resident perceived the care as rough.

During an interview conducted with resident #008, they shared that PSW #118 assisted them with care that day and indicated that the incident caused them to feel upset. Resident #008 stated that RPN #107 was immediately notified of the incident.

During an interview conducted with PSW #118, they acknowledged that they provided assistance to resident #008 on that date. PSW #118 stated that they provided care quickly. PSW #118 stated that RPN #107 witnessed the later part of the incident.

During an interview conducted with RPN #107, they stated that they were informed of the incident by resident #008 and PSW #118. RPN #107 stated that resident #008 appeared emotionally distraught as a result of the incident. RPN #107 stated that they considered the incident to be abuse.

A review of the LTCH's investigation notes concluded that abuse occurred.

During an interview, the Administrator stated that they considered "rough care" to be a form of abuse and that the home had zero tolerance for this type of approach.

The licensee failed to protect resident #008 from abuse by a staff member during the provision of care that resulted in a negative emotional impact. (218).

D) During the above internal investigation, resident #027 was also interviewed about the care they had received in the past from PSW #118. The resident voiced concern to the DRC that PSW #118 was rough with them during care on an identified date in 2018. This was documented in the home's internal investigation notes. In an interview with the resident, they expressed to the LTC Inspector that the incident with the PSW made them feel upset. During an interview with LTC Inspector #218, the Administrator and DRC both confirmed that resident #027 was not protected from emotional abuse by PSW #118. (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 23, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 18th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Jessica Paladino

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