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 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2018	2018_716554_0009	015247-18	Resident Quality Inspection

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Fenelon Court
44 Wychwood Crescent FENELON FALLS ON K0M 1N0

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

KELLY BURNS (554), SARAH GILLIS (623)

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): June 28-29, July 03-06, July 09-13, and July16-17, 2018.

Resident Quality Inspection Intake #015247-18, and concurrent intakes #017214-17, #018250-17, #019935-17, #022912-17, #024411-17, #026719-17, #026754-17, #026757-17, #026969-17, #027993-17, and #001738-18.

Summary of Intakes:

1) #017214-17 - Complaint - improper care and treatment of a resident, alleged;
2) #018250-17 - Critical Incident Report (CIR) - alleged abuse resident to resident;
3) #019935-17 - CIR - alleged abuse, resident to resident;
4) #022912-17 - Complaint - resident care concerns;
5) #024411-17 - CIR - an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition;
6) #026719-17 - CIR - alleged abuse, staff to resident;
7) #026754-17 - CIR - an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition;
8) #026757-17 - CIR - alleged abuse, staff to resident;
9) #026969-17 - CIR - alleged abuse, staff to resident;
10) #027993-17 - CIR - alleged abuse, staff to resident;
11) #001738-18 - CIR - an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition.

During the course of the inspection, the inspector(s) spoke with Executive Director, Interim Director of Care, Corporate Clinician (Revera), RAI-Coordinator, Nutritional Care Manager, Program Manager, Environmental Services Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Housekeeping Aid(s), Dietary Aid(s), Activation Aid(s), Physiotherapy Assistant, Physiotherapist, External Contracted Services Representatives, Resident Council President, Families, and residents.

During the course of the inspection, the inspector(s) toured the long-term care home, observed dining and nutritional care meals and snack services, staff to resident interactions, resident to resident interactions, reviewed clinical health records for identified residents, licensee investigations related to identified intakes, Resident Council Meeting minutes, specific training records related to zero tolerance of abuse and neglect of residents, program evaluation relating to zero tolerance of abuse, falls prevention and management, and infection prevention and control, reviewed Physician's Advisory Committee meetings, and reviewed licensee policies, specifically Resident Non-Abuse Program, Dementia Care Assessment and Care Planning, Lifting Transferring and Repositioning Devices, Fall Prevention and Injury Reduction Program, Post Fall Clinical Pathways, Head Injury Routine, Complaint Management, Urine Odour Audit, Floor Washing, Carpet Shampooing,

Daily Cleaning Sequence, Cleaning and Disinfecting Procedures, Infection Control Program, Management of Personal Belongings, Routine Practices and Additional Precautions, and Medication Incidents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents are fully respected and promoted, specifically failed to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

During an identified date during this inspection Inspector #554 observed the following:

A Personal Support Worker (PSW) #112 and an unidentified PSW were providing care to a resident without the door to the room closed. PSW's noted the Inspector's presence and closed the door to the room.

The next day Inspector #554 observed the following.

An identified resident room – PSW #100 and PSW #102 were providing personal care to a resident. The door to the room was open to the hallway and the privacy curtain was not drawn. The resident could be observed from the hallway. During this same observation, PSW #100 and #102 were heard talking over the resident, the conversation was not resident focused, this conversation was heard by Inspector #554 from the hallway.

PSW #112 indicated, to Inspector #554, that staff are to close doors and or draw privacy curtains when providing resident's with care. PSW #112 indicated that the door to the resident's room (initial observation) must have opened on it's on.

PSW #100 indicated to Inspector #554, an awareness that resident's dignity is to be maintained while providing care, which includes drawing the privacy curtain, and/or closing the door to the room, depending on resident's accommodation type. PSW #100 indicated they should have drawn the privacy curtain while providing personal care to the resident. PSW #100 indicated that the conversation observed was not resident focused nor appropriate.

Registered Nurse (RN) #101 indicated to Inspector #554, that staff are aware and expected to draw privacy curtains and/or close doors when providing care to residents. RN further indicated that care of a resident should always be resident focused which includes conversation during care.

The Director of Care (DOC) indicated to Inspector #554, that the expectation is that staff

will provide personal care to residents in a dignified manner, which includes drawing privacy curtains and or closing doors when providing care. DOC indicated that conversations in a resident's presence should be resident focused.

The licensee has failed to ensure that the rights of residents are fully respected and promoted, specifically failed to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 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 there is a process in place, and monitored to ensure that resident's rights are fully respected and promoted, specifically that every resident is treated with courtesy and respect, and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Related to Intake #024411-17:

The DOC submitted a Critical Incident Report (CIR) to the Director on an identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #046 had an identified incident on an identified date, which resulted in injury.

The clinical health record for resident #046, for a specified period, were reviewed by Inspector #554. Resident #046 is identified, by registered nursing staff to be at risk for falls. Resident had falls on identified dates.

SALT (Safe Ambulation, Lift and Transfer) Assessment (identified date) directs:
- one person constant assistance is required for ambulation, transfers and/or lifts.

The written plan of care on an identified date outlined specified interventions for falls and transfers.

The same interventions are identified in written care plan (identified date).

PSW #125 and PSW #128 indicated, to Inspector #554, that the SALT assessment (identified date) and the written care plans (two identified dates) are 'confusing'. PSW #125 could not recall resident #046's activities of daily living (ADL) during the identified period.

Physio-Therapy Assistant (PTA) indicated to Inspector #554, that the assessment by the Physiotherapist (PT) at that time, assessed the resident to be a two person assist for ambulation and transfers. PTA indicated that resident #046's abilities changed the following month and resident was reassessed by PT on an identified date, to require one staff for assistance in ambulation and transfers.

On an identified date, resident #046 had an identified incident, sustained injury, was transferred to hospital and underwent treatment for injuries sustained (CIR). Resident returned to the long-term care home on an identified date.

Physiotherapist Assessment (identified date):
- Inability to walk, complaints of discomfort
- ROM (range of motion) restricted identified extremity
- Transfer Ax2
- Ambulation – none at this time

SALT Assessment (identified date) directs:
- one person constant physical assistance is required for ambulation, transfers and/or lifts

- mechanical lift – two staff members required, using an identified transfer/lift device

The written plan of care on an identified date outlined specified interventions for falls and transfers.

PSW #125 and PSW #128 indicated that the SALT assessment (identified date) and the written care plans (identified date) are 'confusing' and 'make no sense'. Both PSW's could not recall resident #046's ADL's when the resident returned to the long-term care home on an identified date, but believes resident would have been an identified transfer device, and would have required total assistance for all transfers at that time.

The DOC indicated, to Inspector #554, that the SALT assessments and written care plans, for resident #046 during the identified period, were unclear, and would be confusing for direct care staff and or others to follow when providing care to resident #046.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care resident #046, specifically related to mobility, transfers and Fall Risk. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #047 as specified in the plan.

Related to Intake #001738-18:

The ED submitted a Critical Incident Report (CIR) on an identified date, with regards to an incident that causes an injury for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #047 had an identified incident days earlier, and was later transferred to hospital.

PSW #120, and PSW #121 indicated, to Inspector #554, that resident #047 was known to be at risk for falls.

The clinical health record, for resident #047, was reviewed for an identified period. Documentation by registered nursing staff, indicates that resident #047 had an identified number of falls on identified dates.

The written plan of care on an identified dates outlined specified interventions for falls, toileting and risk related to prescribed drugs.

The clinical health record, for resident #047, fails to provide support that resident was transferred to hospital for assessment following identified unwitnessed falls, one of which resulted in identified injuries. There is no documentation to support that a Physician was contacted on the above identified dates for direction.

RN #101 indicated to Inspector #554, that each resident has an individualized plan of care and indicated that the plan is to be followed, unless indicated otherwise.

RN #122, who was the Charge Nurse on an identified date, was unavailable for an interview during this inspection.

DOC (Interim) indicated to Inspector #554, that if a resident is prescribed an identified medication and has a unwitnessed fall, and/or sustains or is suspected of sustaining an identified injury, the expectation is that the resident is transferred immediately to the hospital for assessment.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #047 as specified in the plan. [s. 6. (7)]

3. 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.

Related to Intake #024411-17:

The DOC submitted a CIR to the Director on an identified date, with regards to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #046 had an identified incident a day earlier and sustained injury.

The clinical health record for resident #046, for the identified period, was reviewed by Inspector #554. Resident #046 is identified, by registered nursing staff to be at risk for falls. The clinical health record indicates that resident #046 had an identified number of falls between these dates.

The following assessments and progress notes were documented in the clinical health record:

Physiotherapy Assessment (identified date) directs:

- utilizes a mobility device with assistance of staff – transfers assist x 1

SALT (Safe Ambulation, Lift and Transfer) Assessment (identified date) directs:
- one person constant assistance is required for ambulation, transfers and/or lifts

A progress note, on an identified date, indicated that resident #046 had an unwitnessed fall. Resident was expressing discomfort, registered nursing staff unable to assess injuries. Resident #046 transferred to hospital for assessment.

Physiotherapy Assessment directs:
- identified mobility device, assist of one staff (Ax1) – transfers Ax1 (identified date)

A progress note on an identified date indicated that the Substitute Decision Maker (SDM) updated, by registered nursing staff, with regards to a change in resident #046's health status. SDM provided reassurance by registered nursing staff that resident #046 would be monitored 'closely' and would be provided assistance with all transfers. SDM voiced concerns regarding resident incident and asked that staff walk with resident to avoid falls.

A progress note on an identified date indicated that resident #046 had an unwitnessed fall. Resident #046 had not being using a mobility aid, and was returning from an identified area. Resident was assessed by registered nursing staff to have no injury.

Physiotherapy Assessment directs:
- Ax1 – identified mobility device assisted by others (identified date)

A progress note on an identified date indicated that resident #046 had an unwitnessed fall. Resident #046 sustained injury, had complaints of discomfort.

Physiotherapy Assessment directs:
- identified mobility device Ax1 staff – another identified mobility device by self (identified date)
- identified mobility device Ax2 x identified distance, staff, transfers x 2 staff, another mobility device by self (identified date)

The written plan of care on an identified dates outlined specified interventions for falls, toileting and transfers.

Physiotherapy Assessment directs:
- identified mobility device Ax1 staff (identified date)

A progress note on an identified date indicated that resident #046 had an unwitnessed fall and complained of discomfort. Assessed by registered nursing staff to have sustained injury. Resident #046 transferred to hospital for assessment and treatment.

PSW #128 indicated to Inspector #554 that staff did not assist resident #046 with ambulation, indicating resident used a mobility aid and was independent with ambulation. PSW #128 indicated resident #046 would toilet themselves.

RN #123 indicated to Inspector #554 that resident was assessed by the PT and a SALT assessment as needing assistance, of one to two staff, with ambulation and transfers. RN #123 indicated that staff are to follow ambulation, transfer and lift assessments as directed by PT and the SALT assessment.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident #046 as specified in the plan, specifically planned care based on the assessment of the PT. [s. 6. (7)]

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

Related to Intake #018250-17:

A CIR was submitted to the Director on an identified date, for an incident that occurred a number of days earlier and was called to the after-hours line on the same day. The CIR indicated that resident #053 was in their room at the time of the incident. Resident #020 was at the doorway to resident #053's room. Resident #053 was upset that resident #020 was in the doorway and began to move their mobility device towards resident #020. Resident #020 exhibited a responsive behaviour towards resident #053, resident #053 continued to move their mobility device forwards and into resident #020.

The written plan of care on an identified date outlined specified interventions for mobility and responsive behaviours.

Review of the plan of care that was in place on an identified date, for resident #053

identified interventions specific to mobility and responsive behaviours.

Resident safety, exhibited responsive behaviour during the operation of the mobility device and the safety of other residents, is not identified in either plan of care.

Review of the progress notes for a specified period identified a specified number of incidents where resident #053 exhibited an identified responsive behaviours towards other residents while operating a mobility device, was spoken to by staff, management and or SDM regarding the exhibited behaviour and was assessed or reassessed by nursing staff, PT and or service provider specific to safety while operating the mobility device.

The written plan of care in PCC does not identify that resident #053 exhibits responsive behaviours towards other identified residents. Resident #053 is known to use an identified mobility device unsafely around other residents. A safety assessment was conducted on an identified date by physiotherapy. At that time the resident was able to pass the assessment and deemed capable of safely operating the mobility device. Resident #053 continued to use the mobility. A second safe driving test was conducted on an identified date when it was requested by the SDM. It identified that resident #053 was declining in their ability to safely operate the mobility device and another mobility device was ordered. The resident continued to use the mobility device and during struck another resident. At that time the mobility device was placed into an identified mode, while awaiting the new mobility device. On an identified date, RN #123 Acting DOC reinstated the mobility device privilege with restrictions to use the device in the resident's room and other specified areas. There are documented instances following this date, when resident #053 was not compliant with the restrictions. On an identified date, an incident occurred when resident #053 drove their mobility device into their bed frame resulting in injury to themselves that required treatment at the hospital. On an identified date, documentation indicated that the mobility device was removed from the residents room.

The plan of care did not identify responsive behaviours exhibited by resident #053 related to an identified responsive behaviour while using the mobility device, or safety risk related to the safe use of the mobility device. Following each documented incident of the identified responsive behaviour, the plan of care was not updated to reflect the changes for resident #053's care needs.

The licensee failed to ensure that the plan of care is reviewed and revised at least every

six months and at any other time when the resident's care needs change of care set out in the plan is no longer necessary. [S. 6. (10) (b)]

5. The licensee failed to ensure that residents are being reassessed and the plan of care is being revised because the care set out in the plan has not been effective, and that different approaches had been considered in the revision of the plan of care.

Related to Intake #001738-18:

The ED submitted a CIR on an identified date, with regards to an incident that caused an injury for which the resident is taken to hospital and which results in a significant change in the resident's health status. The incident involved resident #047 having a fall.

PSW #120, and PSW #121 indicated to Inspector #554 that resident #047 was known to be a risk for falls.

The clinical health record, for resident #047, was reviewed for an identified period.

The written plan of care on an identified dates outlined specified interventions for falls, toileting and visual impairment.There were no new interventions documented during this review.

Documentation in the clinical health record, by registered nursing staff, indicates that resident #047 had an identified number of falls during the identified review period. Resident #047 sustained injury in a few of the documented fall incidents. There is no documentation that planned interventions in place prior to each fall had been reviewed and or revised.

PSW #120 and PSW #121 indicated that the majority of resident #047's falls occurred during a specific shift, when resident was attempting to go to an identified area. Both PSW's indicated that resident would forget to ring for assistance with toileting, and that resident #047 could be unsteady, despite use of a mobility device.

RN #123, who was a Charge Nurse (on an identified shift), indicated to Inspector #554, that the planned care for a resident who has fallen is to be reviewed and revised as part of the post-fall assessment. RN #123 indicated that noting that resident #047's falls were occurring during specific shifts and were specific to resident trying to get to and from a specific area in the home, that different approaches should have been considered to

prevent falls and intern prevent potential injury to resident #047.

The clinical health record fails to provide support that the planned care for resident #047 was reassessed when the planned care had been ineffective and failed to provide support that different approaches had been considered, specific to falls prevention and mitigating risk associated. The last revision of the falls prevention focus, and related interventions on a identified date, resident fell an identified number of times following this date.

The licensee failed to ensure that resident #047 was reassessed and the plan of care was revised when the care set out in the plan had not been effective, and that different approaches had been considered in the revision of the plan of care. [S. 6. (11) (b)]

6. The licensee failed to ensure that residents are being reassessed and the plan of care is being revised when the care set out in the plan has not been effective, and that different approaches have been considered in the revision of the plan of care.

Related to Intake #026754-17:

The ED submitted a CIR to the Director on an identified date, for an incident that caused an injury to a resident for which the resident was taken to hospital, and which resulted in a significant change in the resident's health status. The fall incident involved resident #045.

The clinical health record was reviewed, by Inspector #554, for an identified period. Resident #045 was assessed as a fall risk. The written plan of care on an identified date outlined specified interventions for falls, bed mobility and PASD's.

The progress notes indicated resident #045 fell on identified dates. Documentation provided details of the incident, what lead up to the incident, associated injury if any and exhibited responsive behaviour of resident #045. During an identified date, resident #045 required transfer to the hospital due to injury sustained.

PSW #121 indicated to Inspector #554, that they were on when resident #045 had fallen and sustained injury. PSW #121 indicated that on the identified date resident #045 had been exhibiting identified responsive behaviours and was frequently putting their safety devices down. PSW #121 indicated being uncertain why resident #045 was exhibiting behaviours that shift. PSW #121 indicated resident was found on the floor, on the

identified date, resident's one safety device was down and the safety alarm had been removed. PSW #121 indicated resident was known to put their safety device down and was known to remove the safety alarm.

RN #123, who was a Charge Nurse during the review dates, indicated to Inspector #554 that resident #045 was at risk for falls. RN #123 indicated that resident #045 was known by nursing staff to put down their safety devices and unclip the safety alarm. RN #123 indicated they had witnessed resident #045 on occasion unlatch the locking mechanism on the safety device. RN #123, who is currently the Interim DOC, indicated that the plan of care, specifically the safety device and the safety alarm were not an effective intervention, and indicated that no other approaches and or interventions had been considered at that time.

The licensee had failed to ensure that residents are being reassessed and the plan of care is being revised when the care set out in the plan has not been effective, and that different approaches have been considered in the revision of the plan of care, specific to resident #045 related to fall prevention and management. [s. 6. (11) (b)]

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 there is a process in place, and monitored ensuring that plan of care, for each resident, sets out clear directions to staff and others who provide direct care to the resident; that the care set out in the plan of care is provided to residents; that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change of care set out in the plan is no longer necessary; and that residents are being reassessed and the plan of care is being revised because the care set out in the plan has not been effective, and that different approaches had been considered in the revision of the plan of care., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During the initial tour of the long-term care home, the Wellness Rooms, on two resident home areas (RHA) were found unlocked. The two Wellness Rooms are located on the identified RHA's, both rooms have door knobs that are equipped with locks. The Wellness Rooms contained, a number of cylinders of oxygen.

The Wellness Rooms were found unlocked during four dates during this inspection. Residents were observed within the vicinity of the Wellness Rooms on all identified dates.

PSW #112 indicated to Inspector #554 that the Wellness Rooms were supposed to be locked, and were not considered resident areas.

RN #123 indicated to Inspector #554 being a staff RN in the long-term care home before assuming the position of Interim DOC. RN #123 indicated that staff had been spoken to last fall, by the DOC (at that time), regarding concerns that Wellness Rooms were being left unlocked. Interim DOC (RN #123) indicated that the Wellness Rooms were not to be left unlocked, as such were considered non-residential areas.

The licensee has failed to ensure that doors leading to non-residential areas, are equipped with locks to restrict unsupervised access to those areas by residents, and are kept locked when they are not being supervised by staff. [s. 9. (1) 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 there is a process in place, and monitored ensuring that doors leading to non-residential areas, are equipped with locks to restrict unsupervised access to those areas by residents, and are kept locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage 1 of the RQI inspection, room odours were identified as a triggered item. Upon inspection for room odours, it was identified that the carpet appears soiled/stained in several areas of the home.

Throughout Stage 1 of the RQI inspection, Inspector #623 observed there to be what appeared to be stains on the carpets in various areas throughout the home. Inspector #623 completed a tour of the home with the focus on the carpets. All common areas and hallways are carpeted except for dining rooms.

Inspector #632 identified stained carpeting throughout the LTCH, specifically the main

lounge and foyer, in identified RHA's including hallways, lounges, common areas and in eight resident rooms.

During an interview with Inspector #623, the ESM indicated that there is a process in place for the routine cleaning of the carpets in the home. Once a month there is a contracted service provider that comes into the home and cleans the carpets, each time they clean a different area of the home. ESM indicated dates when carpeting was last cleaned in two identified RHA's. The carpets in both home areas appear to be stained despite the recent cleaning. The ESM indicated that they complete all spot cleaning of any spills that happen. If there is a spill on the carpet in a home area after hours, the nursing staff are to try and soak up as much as possible with a rag, then in the morning ESM will clean the area with the spot cleaning machine. If it happens during the day, ESM will tend to it immediately. The ESM indicated that the Housekeeping, Maintenance and Laundry departments are a contracted service in the home. Annually, the contracted service brings in an external service provider to complete a deep clean, floor stripping and polishing, carpet cleaning. The external service provider is in the home for three days and clean the floors in the entire home. This service was last completed the previous year. The ESM indicated that the building is built on a swamp and they are unsure if the concrete floor under the carpet was sealed properly. The ESM indicated that with the heat and humidity, moisture from the concrete comes up through the floor and will show the old stains that were never cleaned properly. ESM indicated that because of this, despite cleaning, the carpets will look stained in the summer months when it is warmer.

During an interview with Inspector #623, the ED indicated that there are no plans this year to replace any of the carpeting in the home. The ED indicated that the carpets in the home are cleaned frequently but even after a stain has been removed from the carpet and the carpet shampooed, within a day the stain will resurface. The ED indicated that they were told that the concrete floor below the carpet was never sealed properly and it allows moisture up through the floor causing the carpet to appear stained.

Despite the home having a process in place for routine cleaning of the carpets, as well as a process for spot cleaning of stains and spills. Within one day of being cleaned, the carpets continue to appear stained. The ED indicated during an interview that there are no plans in place for the replacement of carpets in the home this year.

The licensee has failed to ensure that the home, furnishings and equipment, are maintained in a good state of repair, specifically the carpets in the home. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Pursuant to O. Reg. 79/10, s. 2 (1) for the purposes of the definition of 'abuse' in subsection 2 (1) of the Act,

- 'emotional abuse' means (a) any threatening, insulting, intimidating, or humiliating gestures, actions behaviours or remarks, including imposed isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

-'verbal abuse' means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity, or self-worth that is made by anyone other than a resident.

The licensee's policy, Resident Non-Abuse Program indicates that Revera is committed

to providing a safe and supportive environment in which all residents are treated with dignity and respect. The Resident Non-Abuse Program policy indicates that the licensee has a zero tolerance for abuse and neglect.

The ED indicated to Inspector #554 that all staff are provided with training, specific to the licensee Resident Non-Abuse Program, and S.T.O.P interventions training program upon hire and annually. All staff must sign a Resident Non-Abuse Acknowledgement form annually thereafter.

The ED indicated that the abbreviation 'S.T.O.P' means to, 'Stop what you are doing, Think of alternatives, Observe the resident and the environment and Plan another approach'. ED indicated that STOP is an intervention that staff are taught, and are to use when interacting with residents who are exhibiting a responsive behaviour.

Related to Intake #026757-17:

On an identified date, the ED submitted a CIR to the Director regarding an alleged incident of staff to resident abuse. The alleged abuse incident was said to have occurred on a previous identified date. The CIR indicates that on an identified date, a visitor reported that they were visiting another resident in the long-term care home (LTCH) a few weeks ago, indicating they believed the date to be on a previous identified date, when they heard a staff member speaking loudly to a resident.

The ED indicated to Inspector #554 that during the licensee's investigation it was determined that the resident involved was resident #019, and that the staff involved was PSW #114, as they were the PSW who worked on the identified RHA during that time.

The clinical health record for resident #019 was reviewed for an identified period.

The written plan of care on an identified date outlined specified interventions for cognitive function and care needs.

Resident #019 was interviewed, by Inspector #554 on an identified date. Resident #019 was not oriented to date or time, but was aware that they resided in the home. Resident #019 was unable to provide specifics of the alleged incident on an identified date, but indicated that PSW #114 was mean, had refused at times to provide care and had been rude. Resident #019 indicated not being liked by PSW #114. Resident #019 indicated being made to feel sad by the PSW.

PSW #114 was not available for an interview during this inspection.

The ED indicated that during the investigation resident #019 was interviewed by the ED and DOC. ED indicated that during the interview, 'resident #019 stated that knew they asked too many questions, and that staff speak firmly to them as that is what is needed'. ED indicated that resident #019 indicated PSW #114 did not treat the resident with dignity.

The ED indicated that the investigation involving the alleged staff to resident abuse, which was said to have occurred on an identified date, was inconclusive as PSW #114 denied the abuse allegation. The ED indicated that PSW #114 returned to their normal duties as a PSW following the investigation.

The ED indicated that PSW #114 has been involved in other incidents involving interactions with residents and failing to provide resident with necessities. The ED indicates that the licensee had investigated incidents involving PSW #114.

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

2. Related to Intake #026719-17:

On an identified date, the ED submitted a CIR to the Director regarding an alleged incident of staff to resident abuse. The alleged abuse occurred a day earlier and involved residents #009, #010, and #042. The staff involved in the alleged abuse of the residents was PSW #114. The incident on the identified date was witnessed by Activation Aid (AA) #115.

Resident's #009, #010, and #042 were interviewed by Inspector #554 and did not recall the alleged incident.

AA #115 indicated to Inspector #554 that they heard PSW #114 speak inappropriately to residents #009 and #010 on the identified date. AA #115 indicated that resident #042 was exhibiting an identified responsive behaviour that evening. AA #115 indicated that following the interaction between PSW #114 and resident #042, resident #010 was seen and heard consoling resident #042, and PSW #114 was heard speaking inappropriate to the resident. AA #115 indicated at that time, residents #010 and #042 were taken to the

front lounge area for an activity program with the goal of redirecting and consoling both residents. AA #115 indicated that resident #042 continued to be upset. AA #115 indicated that PSW #114's actions on the identified date, were abusive. AA #115 indicated the incident was reported to AA #129 and together they reported the incident to either the Charge Nurse, RN #101, or the ED, who was in the LTCH.

In a written statement, AA #129 indicated to ED, that they had heard PSW #114's interaction with resident #009, telling resident #009 to stop the behaviour. AA #129 indicated in a written statement to ED, that the incident was reported to RN #101, who indicated that they had spoken to PSW #114 in the past about their actions.

PSW #114, AA #129 and RN #101 were not available for an interview during this inspection.

The ED indicated to Inspector #554 that during the licensee's investigated the incident. ED indicated that PSW was asked to review Resident's Non-Abuse and Managing Responsive Behaviours policies. ED indicated that PSW #114 returned to their normal work routine on an identified date. The ED indicated that PSW #114 has been involved in other incidents involving interactions with residents. ED indicates that the licensee had investigated other incidents of alleged abuse of residents by PSW #114.

The licensee failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or the staff in the home, specifically by PSW #114.

3. Related to Intake #027993-17:

On an identified date the ED submitted a CIR to the Director regarding an alleged incident of staff to resident abuse. The alleged abuse involved PSW #114 and resident #019.

PSW #112 indicated to Inspector #554 that resident #019 indicated that on an identified date, PSW #114 was mean to the resident. PSW #112 indicated that resident indicated that PSW #114 refused to remove a transferring device from under the resident. PSW #112 indicated reporting the abuse allegation to the ED that same day.

Resident #019 was interviewed by Inspector #554. Resident #019 was unable to provide specifics of the alleged incident on the identified date, but indicated that PSW #114 was mean, had refused at times to provide care and had been rude.

PSW #114 was not available for an interview during this inspection.

The ED indicated to Inspector #554 that the abuse allegation involving PSW #114 towards resident #019 was investigated. ED indicated that both the ED and the DOC interviewed staff and resident #019. ED indicated that resident #019 indicated the resident had asked PSW #114 to remove the transferring device, on the identified date, and indicated that PSW #114 refused. ED indicated that during the interview with resident #019.

ED indicated that PSW #114 was interviewed. ED indicated that PSW #114 indicated in the interview that they did not remove the transferring device as requested by resident #019. ED indicated that PSW #114 indicated in the interview that resident #019 'won't listen or follow directions'. ED indicated that when PSW #114 was asked why they did not use the STOP approach with resident #019, PSW #114 indicated that the licensee's STOP Program doesn't work, and that the RHA is 'ridiculous' with residents with identified diagnoses.

The ED indicated to Inspector #554 that during the licensee's investigation it was determined that the abuse allegation was founded. ED indicated that PSW #114 was asked to review Resident's Non-Abuse and Safe Resident Handling policies. ED indicated that PSW #114 returned to their normal work routine on an identified date.

ED indicated that PSW #114 has been involved in other incidents involving interactions with residents, and allegations of abuse. ED indicates that the licensee had investigated the incidents involving PSW #114.

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

4. On an identified date, the ED submitted a CIR to the Director, regarding alleged staff to resident abuse. The incident involved PSW #114 towards resident #056.

The ED indicated being called by RPN #104 who had indicated that PSW #114 had spoken inappropriately to resident #056 during the dining room meal service. ED indicated that the incident was witnessed by staff and residents.

RPN #104 was unavailable for an interview during this inspection.

PSW #114 was not available for an interview during this inspection.

The ED indicated to Inspector #554 that during the licensee's investigation it was determined that the abuse allegation was founded. ED indicated that as of an identified date, PSW #114 is no longer working at the LTCH.

The licensee failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or the staff in the home, specifically related to abuse of residents by PSW #114. [s. 19. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions.

Canadian Standards Association (CSA) standard for the 'safe storage, handling, and use of portable oxygen systems in residential buildings, and health care facilities', directs the following:

- Gas Cylinders - must be secured in racks or by chains

During the initial tour of the long-term care home, the Wellness Rooms, on two identified

resident home areas (RHA) were found unlocked and containing an identified number of oxygen cylinders.

Wellness Room (identified location) was observed, by Inspector #554, to have an oxygen cylinder sitting upright on the floor. Another identified location was observed to have oxygen cylinders sitting upright and on the floor. None of the identified oxygen cylinders observed on the identified date were secured within a cylinder rack or by other means.

Unsecured oxygen cylinders were observed on the floor, in the Wellness Rooms, on both RHA's, on four other dates during this inspection.

The contracted service provider for oxygen at Fenelon Court was contacted by Inspector #554. The contracted service provider representative, who works in the respiratory department for the contracted service provider, indicated to Inspector #554 that long-term care home (LTCH) would have been provided the 'CSA standards for the safe storage, handling and use of oxygen when the initial contract for oxygen in the LTCH was set up. The representative indicated being unsure when the initial contract was set up, and believes that the contract would have been with the Director of Care and or the Executive Director. The contracted service provider representative indicated that oxygen cylinders are to be stored in cylinder racks provided when not in use for residents.

RN #123 indicated to Inspector #554 being a staff RN in the long-term care home before assuming the position of Interim DOC. RN #123 indicated that staff had been spoken to last fall, by the DOC (at that time), regarding concerns that oxygen cylinders were not being stored in cylinder racks. Interim DOC (RN #123) indicated that the oxygen cylinders were considered equipment/supplies. DOC indicated that oxygen cylinders are to be stored securely in cylinder racks when not in use, and indicated registered nursing staff area aware of this requirement.

The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, specifically safe storage of oxygen cylinders. [s. 23.]

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 there is a process in place, and monitored ensuring hat staff use all equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #7: 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 :

The licensee has failed to ensure that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the care of new items, or acquiring.

During stage 1 of the RQI observation notes by Inspector #554 of resident #019's bathroom identified on two identified dates, that the urinal was observed on the back of the toilet, the urinal had a dark black staining. A identified number of days later, Inspector #623 observed in resident #019's bathroom on the back of the toilet, a urinal unlabelled with dark staining. On an identified date, observations in a resident home area by Inspector #623, identified the following residents had a urinal in their bathroom that was unlabelled; #041,#049, #050, #051, #008, #019, #052, #009 and #011.

During an interview with Inspector #623, PSW #102 indicated that they were unaware of how to get a replacement urinal or bedpan if required. PSW #102 indicated that urinals

are intended to be used by a single resident, not shared, but they are not labelled with a resident's specific name.

During an interview with Inspector #623, PSW #100 indicated urinals are supposed to be labelled but very few actually are.

During an interview with Inspector #623, the corporate Clinician from Revera who was in the home at the time, indicated that urinals are considered personal equipment and are dedicated to one resident. The corporate Clinician indicated that residents who are in private rooms do not have personal items labelled, residents in a shared room require all personal items to be labelled.

The licensee failed to ensure that residents have their personal items labelled within 48 hours of admission and in the case of new items, of acquiring, including urinals. [s. 37. (1) (a)]

2. The licensee failed to ensure that each resident has their personal items, including personal aids, labelled within forty-eight hours of admission, and of acquiring, in the case of new items.

During the initial tour of the long-term care home, the following was observed by Inspector #554:
- Unlabelled personal items in identified tub-shower rooms on three RHA's.

PSW #100, and RN #101 indicated to Inspector #554, that personal items are to be individually labelled for use. Both PSW #100, and RN #101 indicated that night PSW's are responsible for labelling of personal items.

The DOC indicated that personal items are to be labelled for individual resident use, but indicated, that it has been the practice in the long-term care home, as well as a Revera practice, to label personal items only if residents share a room with another resident.

The licensee has failed to ensure that each resident has their personal items, including personal aids, labelled within forty-eight hours of admission, and of acquiring, in the case of new items. [s. 37. (1) (a)]

3. The licensee has failed to ensure that the residents have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

During stage 1 of the RQI observation notes by Inspector #554 of resident #019's bathroom identified on two identified dates, that the urinal was observed on the back of the toilet, the urinal had a dark black stains. An identified number of days later, Inspector #623 observed in resident #019's bathroom on the back of the toilet, a urinal unlabelled with dark staining in the bottom and at the top opening.

During an interview with Inspector #623, PSW #102 indicated that they were unaware of when or how urinals were cleaned. The PSW indicated that resident #019's urinal is heavily soiled and stained and they rinse the urinal after every use and spray with an identified product into the urinal to mask the smell. PSW #102 indicated that they were unaware of how to get a replacement urinal or bedpan if required.

During an interview with Inspector #623, PSW #100 indicated that when working on a particular shift, there is no specific routine or schedule for cleaning of resident's equipment, including bed pans and urinals. The PSW indicated that they would clean a urinal by filling it with water and adding a denture tablet, then allowing it to soak. The PSW indicated that they would do this when they felt the equipment was soiled. The PSW indicated that most urinals were a solid blue, and you could not see if they were stained inside. PSW #100 indicated that when the new clear urinals came in, it was more evident that the urinals were soiled. If a urinal was particularly dirty, then the PSW indicated they would get a new one and throw out the old.

During an interview with Inspector #623, the DOC indicated that a particular shift PSW's are responsible for cleaning all of the resident's personal equipment for each weekly. The identified PSW's sign off in the shift binder when a resident's equipment has been cleaned, that would include urinal, as well as inspecting the equipment to ensure that it is in good working order. The DOC indicated that urinals are not considered disposable equipment, they are dedicated to one specific resident and they are cleaned weekly. The expectation is that on the scheduled day for cleaning, all equipment would be removed from the resident's room and taken to the soiled utility room for cleaning, then returned to the resident's room before morning. The expectation is that the equipment would be cleaned using soap and water. The DOC indicated that if a urinal was stained despite cleaning, or an odour remained, the expectation is that the staff would get a new urinal. The DOC indicated that there is a supply of new equipment available for staff at all times.

During an interview with Inspector #623, the corporate Clinician from Revera who was in

the home at the time, indicated that denture tablets are not considered a disinfectant that is to be used to clean urinals. There is an appropriate designated disinfectant provided by an identified supplier that is to be used to clean resident personal equipment. The corporate Clinician indicated that the process for weekly cleaning of urinals has not been followed in the home.

Review of the cleaning and disinfecting procedures policy:
Policy: Cleaning and disinfecting resident equipment
Procedure: Clean and disinfect resident equipment or items according to the frequency outlines in the Cleaning and Disinfection of Reusable Non critical Resident Equipment/Items Procedure.

Toileting Equipment – Bed pans, Commodes, Urinal
Frequency – weekly and as needed
Specific Considerations – Dedicated to one Resident
- Clean after each use
- For weekly disinfection, in the sink/hopper designated for dirty/soiled equipment, remove all organic materials first using soap and water and scrubbing as necessary. Soak items in disinfectant for recommended contact time. Rinse and dry.

The licensee failed to ensure that the residents have their personal items, cleaned as required, specifically urinals. [s. 37. (1) (b)]

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 there is a process in place, and monitored ensuring that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the care of new items, or acquiring, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment, and that the plan is implemented.

Related to Intake #024411-17:

Resident #046 is identified, by registered nursing staff to be at risk for falls. The clinical health record for resident #046, for an identified period, was reviewed by Inspector #554. Resident #046 is documented as having had an identified number of falls during the identified period. On an identified date, resident had a fall, sustained injury and was transferred to hospital for assessment and treatment.

Documentation, by registered nursing staff, indicated that resident #046 fell on identified dates. Documentation in the health record documents each incident.

MDS (Minimum Data Set) assessments (identified dates) all identify resident #046 as being assessed as needing assistance with continence management. MDS assessment for an identified date indicated that resident #046 has deteriorated and needed increased care by staff. Goals of care is indicated as 'monitor risk, monitor decline, and to maintain a safe environment'.

The written plan of care on an identified date outlined specified interventions for falls, transferring and toileting.

The same interventions are identified in written care plan (two identified dates), specific to toileting and falls risk.

PSW #128 indicated to Inspector #554 that staff did not toilet resident #046, prior to an identified date, as the resident was independent with use of a mobility aid.

PSW #135 indicated, to Inspector #554 that resident #046 required continence care. PSW #135 indicated that all residents, including resident #046 are toileted every two hours. PSW #135 indicated that there is no individualized plan for continence care for resident #046.

PSW #136 indicated, to Inspector #554 that resident #046 required continence care. PSW #136 indicated that residents, including resident #046 are toileted after meals and at bedtime. PSW #136 indicated that there is no individualized plan for continence care and/or bowel care management for resident #046.

RAI-C (Resident Assessment Instrument – Coordinator) indicated, to Inspector #554 that according to documentation in the clinical health record for resident #046, there was no individualized plan for continence care and/or bowel care management for resident #046. RAI-C indicated documentation indicated that resident #046 requires extensive assistance of one staff for toileting.

The licensee has failed to ensure that there was an individualized plan of care to promote and manage bowel and bladder continence, for resident #046, who was assessed as being incontinent. [s. 51. (2) (b)]

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 there is a process in place, and monitored ensuring that each resident who is incontinent has an individualized plan, as part of his/her plan of care, to promote and manage bowel and bladder continence based on the assessment, and that the plan is implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers are identified for the resident demonstrating responsive behaviours, where possible.

Related to Intake #018250-17:

A CIR was submitted to the Director on an identified date, for an incident that occurred on a previously identified date and was called to the after-hours line on the same day. The CIR indicated that resident #053 was in their room at the time of the incident. Resident #020 was at the doorway to resident #053's room. Resident #053 was upset that resident #020 was in the doorway and began to move their mobility device towards resident #020. Resident #020 then exhibited a responsive behaviour towards resident #053, resident #053 continued to move their mobility device forwards and ran into resident #020 with the mobility device. The incident resulted in resident #053 sustaining injury.

The written plan of care on an identified date outlined specified interventions for responsive behaviours and mobility.

Review of the BSO binder indicated that resident #053 is not identified or monitored as part of the BSO program in the home.

During an interview with Inspector #623, RPN #104 indicated that they were working on an identified date, when the incident occurred involving resident #053 and #020. RPN #104 indicated that the incident was not witnessed, but was reported to them by resident

described what had happened. RPN indicated that staff are aware that resident #053 has no tolerance of some residents. Resident #053 is known to take measures into their own hands to attempt to remove another resident that has entered into their room, including running into them with the identified mobility device. RPN #104 indicated that interventions were in place to prevent other residents from entering resident's #053 room but were not effective. RPN #104 indicated that resident #053 would deny decisions when using the identified mobility device, they would say that the other person ran into them despite the circumstances. The RPN indicated that resident #053 was aware that a condition of keeping the mobility device was that they needed to use it safely. RPN #104 indicated that resident #053's SDM was concerned and often suggested removing the mobility device. RPN #104 indicated that staff felt the mobility device was a way for the resident to be independent with mobility within the home. RPN #104 indicated that resident #053 could safely use the mobility device if the pathway was clear and the hallway was straight, but the resident had difficulty in congested areas with safely using the mobility device around obstacles and would become impatient with other residents. RPN #104 indicated that exhibiting an identified behaviour when using the mobility device is not identified as a responsive behaviour for resident #053 in the plan of care. RPN #104 indicated that there is a BSO PSW for the home, and there are binders available in the nursing station to identify any residents that are followed by BSO, but resident #053 is not on the BSO program.

During an interview with Inspector #623, RPN #124 indicated that they were aware that there was a history of resident #053 exhibiting an identified responsive behaviour when using the mobility device. RPN #124 indicated that they were uncertain if the identified behaviour when operating the mobility device is identified as a responsive behaviour for resident #053. RPN #124 indicated that staff needed to monitor for when resident #053 was using the mobility device, especially in crowded areas.

During an interview with Inspector #623, PSW #121 indicated that resident #053 was not safe operating the mobility device, there were instances of exhibited behaviours towards other residents. PSW #121 indicated that responsive behaviours were not identified in the plan of care for resident #053 related to the risk of using the mobility device around other residents. The PSW indicated that resident #053 was known to take matters into their own hands to remove residents from their space.

During an interview with Inspector #623, the Acting DOC indicated that they were aware that there was a concern with resident #053 exhibiting responsive behaviours when using the mobility device around other residents. The Acting DOC indicated that the plan of

care for resident #053 should reflect the identified responsive behaviour when operating the mobility device and safety risk to other resident's. The DOC indicated that the BSO PSW #112 would be responsible to update that plan of care related to responsive behaviours which should include identified triggers.

The licensee has failed to ensure that behavioural triggers were identified for resident #053 demonstrating an identified responsive behaviours when operating the mobility device with the trigger identified by staff as being specific residents in resident #053's personal space. [s. 53. (4) (a)]

2. The licensee failed to ensure that strategies had been developed and implemented to respond to residents demonstrating responsive behaviours.

Related to Intake #022912-17:

The Business Manager submitted a CIR on an identified date with regards to resident to resident abuse. The alleged incident was said to have occurred a day earlier involving resident #017 and resident #043.

Substitute Decision Maker (SDM) #116 indicated that resident #017 called their home on an identified date and indicated to SDM, that an individual (resident #043) had entered the resident's room, and had been abused by resident #017. SDM #116 indicated that resident #017 was upset and felt unsafe.

PSW #100 indicated, to Inspector #554, that resident #043 is known to exhibit identified responsive behaviours.. PSW #100 indicated that resident #043 will enter other resident's rooms.

The clinical health record, for resident #043, was reviewed, by Inspector #554, for the a period of approximately five months. Documentation reviewed indicated that resident #043 exhibits identified responsive behaviours.

The plan of care reviewed failed to provide evidence to support that strategies had been developed and implemented for resident #043 who had been identified by nursing staff, as exhibiting identified responsive behaviours during the review dates, specifically strategies were not developed for the identified behaviours.

The DOC indicated, to Inspector #554, that strategies should be developed and

implemented for all residents exhibiting responsive behaviours.

The licensee has failed to ensure that strategies had been developed and implemented to respond to residents demonstrating responsive behaviours, specifically resident #043. [s. 53. (4) (b)]

3. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Related to Intake #018250-17:

A CIR was submitted to the Director for an incident that occurred on an identified date and was called to the after hours line the same day, the CIR was submitted to the Director three days later. The CIR indicated that resident #053 was in their room at the time of the incident. Resident #020 was at the doorway to resident #053's room. Resident #053 was upset that resident #020 was in the doorway and began to move their mobility device towards resident #020. Resident #020 reacted to resident #053, resident #053 continued to move their mobility device forwards and ran into resident #020 with the mobility device The incident resulted in resident #053 sustaining injury.

The written plan of care on an identified date outlined specified interventions for responsive behaviours.

Review of the BSO binder for the identified resident home area, does not identify resident #053 as having responsive behaviours. Observation of the name plate outside of resident #053's room does not identify with an identified logo that resident exhibits responsive behaviours.

During an interview with Inspector #623, PSW #121 indicated that resident #053 was not safe using the mobility device there have been too many instances resident exhibiting an identified responsive behaviour towards. PSW #121 indicated that if resident #053 was exhibiting an identified behaviour towards other residents with the mobility device then on occasion the mobility device would be placed into an identified mode, and staff were required to push it. PSW #121 indicated that there has also been a trial where the resident was only allowed to use the mobility device if there was a staff member walking beside them for safety. Resident f#053 believed that they were safe to use and did not understand the safety risk, they felt that they were not at fault if someone was run into,

the other people should not get in resident #053's way. PSW #121 indicated that they were unaware of any interventions for resident #053 that were documented, these were interventions that staff would try as a way of managing resident #053 and to ensure everyone's safety.

During an interview with Inspector #623, RPN #104 indicated that resident #053 has no tolerance for some residents. Resident #053 is known to take measures into their own hands to attempt to remove another resident that has entered into their room. RPN #104 indicated that an identified intervention was in place on the door of resident #053's room in attempt to deter residents from entering. Another identified intervention was also trialed, but was not effective. RPN #104 indicated that resident #053 would deny poor decisions when using the mobility device, they would say that the other person ran into them. Resident #053 was aware that the condition of keeping the mobility device was that they needed to use it safely. RPN #104 indicated that resident #053's SDM frequently expressed concerns that resident #053 was not safe to use the mobility device and often suggested removing. RPN #104 indicated that the BSO PSW #112 was responsible for updating the care plan in Point Click Care related to responsive behaviours, including interventions.

During an interview with Inspector #623, the DOC indicated that the plan of care for resident #053 should reflect the identified responsive behaviour when using the mobility device and risk to others. The DOC indicated that PSW #112 will create a BAT tool for resident's that are identified with responsive behaviours, and develop a plan. The DOC indicated that if a resident is identified as exhibiting responsive behaviours, a fireworks logo is placed on the name plate outside of the residents room. The DOC was unsure if resident #053 has a responsive behaviour care plan that identifies the identified exhibited behaviour associated interventions.

The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, specifically the plan of care for resident #053 that was in place following the incident that occurred on an identified date, where resident #053 exhibited an identified behaviour towards resident #020 when they attempted to enter resident #053's room, does not identify the responsive behaviour and strategies to respond to resident #053's identified responsive behaviour when using a mobility device. [s. 53. (4) (b)]

4. The licensee failed to ensure that strategies had been developed and implemented to respond to residents demonstrating responsive behaviours.

Related to Intake #019935-17:

The ED submitted a CIR to the Director on an identified date, regarding an alleged incident of resident to resident physical abuse. The incident occurred a specified number of days earlier and involved resident #055 towards resident #046.

The clinical health record, for resident #055, was reviewed for the an identified period. The health record identifies that resident #055 exhibited identified responsive behaviours, directed towards other residents and staff on other identified occasions.

PSW #112 indicated, to Inspector #554, that resident was known to exhibit an identified responsive behaviours towards both residents and staff. PSW indicated that resident #055 had used their an identified mobility aid as a weapon.

RPN #130, RN #105, and RN #123, all indicated to Inspector #554, that registered nursing staff were, and remain responsible to update residents' written care plans, especially when a resident is exhibiting responsive behaviours. RPN #130, RN #105, and RN #123 indicated that the written care plan are to include strategies/interventions specific to the identified responsive behaviour in an effort to reduce and or eliminate the behaviour, and to mitigate risk to others.

The written care plan (identified dates) fails to identify agitation and/or aggression as an exhibited responsive behaviours, and failed to identify that strategies had been developed and implemented for all exhibited responsive behaviours for resident #055.

The licensee has failed to ensure that strategies were developed and implemented to respond to residents demonstrating responsive behaviours, specifically resident #055 who was identified as exhibiting identified responsive behaviours towards residents and staff. [s. 53. (4) (b)]

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 there is a process in place, and monitored ensuring that behavioural triggers are identified for the resident demonstrating responsive behaviours; and that strategies had been developed and implemented to respond to residents demonstrating responsive behaviours, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

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

The licensee policy, 'Urine Odour Audit' (#ES-C-25-15) directs that all lingering urine odours of the home are investigated and eliminated.

The policy indicates that the following will occur:
- When a concern of lingering urine odour is detected the 'urine odour audit form' must be completed by the Environmental Services Manager. This audit form will include conclusion and suggested action to eliminate the odours. A copy of the completed audit will be given to the Administrator/Executive Director, and the Director of Care (DOC).
- A solution to the odour concern will be implemented with corrective action taken, completed date, and responsible party recorded on the audit form

During the initial tour of the long-term care home (LTCH) lingering offensive odours were detected in the hallways of the LTCH by Inspector #554. The following areas were

detected to specifically have lingering offensive odours:

- Identified resident home area (RHA) – in the hallway outside of an identified resident room
- Identified RHA – in the hallway outside of four identified resident rooms

Lingering offensive odours were further detected in resident rooms and or RHA hallways, specifically:

- Resident Room (identified) – an odour was detected inside the room, and the washroom. The carpet in room was observed heavily stained, and there was a urinal in the washroom that was observed to have blackish staining inside and along the rim of the urinal. These observations were identified on identified dates.

- Identified RHA – in the hallway outside of four identified resident rooms. The odour was detected throughout the day on identified dates.

- Resident Room (identified) – an odour was detected inside the room. Fluid was observed on the floor in front of a reclining chair, there was staining on the reclining foot rest of the chair, and the pad on the chair appeared wet. This was observed on identified dates.

- Resident Room (identified) – an odour was detected in the room, and the washroom. The lingering offensive odour was detected to be more concentrated within the resident's washroom. Identified equipment were observed in a basin sitting on the floor, adjacent to the toilet. The identified equipment was observed to contain fluid. On an identified date, the fluid in the identified equipment was observed present during the specific hours. The lingering offensive odour was detected in the room and washroom during identified dates during this inspection.

HSK #107 indicated, to Inspectors #554 and #623, that the resident rooms are cleaned including the washrooms daily. HSK #107 indicated that not being aware of the any lingering offensive odours in an identified room.

PSW #135 indicated, to Inspector #554, not being aware of any lingering offensive odours in the identified resident rooms, or in the hallways of the identified RHA. PSW indicated that the fluid in the identified equipment on the identified date was 'urine'. PSW indicated they do not empty the equipment until the end of their scheduled shift. PSW

indicated the identified equipment is left in a basin on the floor in the washroom. PSW indicated that the identified equipment is disconnected from the resident with care, and other equipment is applied. PSW further indicated the odour that Inspector #554 was detecting may be emitting from the identified equipment.

PSW #136 indicated, to Inspector #554, that the lingering offensive odour in the identified resident room may be related to the identified equipment for that resident.

ESM indicated, to Inspector #623, that housekeeping staff clean resident rooms and washrooms daily, if there is an odour detected, then they try to determine where the odour is emitting from, check and empty garbages, check if carpet is stained and clean it as required. If the odour is still present they are to notify ESM for further action to be taken. ESM indicated not being aware of any lingering offensive odours in an identified resident room, until concerns had been brought to their attention this morning (by Inspector #623). ESM indicated that the stained carpet could be a contributing to the odour in the room.

The ESM indicated that he/she was aware of the lingering offensive odour in an identified resident room, indicating that the odour was related to a nursing issue and not related to housekeeping. ESM indicated they had completed 'urine odour audits' specific to odour concerns in this room, and that the odour in the room were first noted on an identified date ESM indicted at that time, the contributing factor to the odour was suggested to be emitting from the resident #54's assigned equipment, and identified fluid on the floor in the resident's washroom. ESM indicated that the outcome of the audit was shared with the DOC. ESM indicated that the odour may be related to spilt identified fluid leaking into the flooring in the washroom, but indicated as of this time, no plans were in place to address the odour in the room, other than daily cleaning.

The DOC indicated, to Inspector #554, not being aware of any concerns with the lingering offensive odour in the identified room. The DOC attended the room with Inspector #554, DOC indicated that the resident used equipment was a factor contributing to the lingering offensive odour in the room. DOC indicated not seeing the 'urine odour audits' specific to the identified room and had not heard of any care concerns related to resident #054, and or resident's equipment.

During separate interviews, both the ESM and the DOC indicated that the expectation is that there is no lingering offensive odours in the LTCH.

The licensee has failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Additional Required Actions:

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

WN #11: 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 failed to ensure that staff participate in the implementation of the infection prevention and control program.

During the initial tour of the long-term care home (LTCH), the following was observed by Inspector #554:

- Room (identified) was observed to have a yellow bag hanging on the door to the room containing personal protective equipment (PPE). The yellow bag contained identified PPE's. There was no signage indicating type of isolation and/or precaution in place. The room, is shared by two residents. The resident room is located on an identified resident home area. PSW #100 indicated a resident in the room was in isolation.

- Room (identified) were observed to have a caddy, on wheels, outside the door of the room. The caddy contained identified PPE's. There was no signage indicating type of isolation and/or precaution in place. The resident room is located on an identified RHA. During this observation PSW #100 was observed, inside the room, providing care to

resident #044. PSW #100 was not wearing PPE while providing care to resident #044.

PSW #100 indicated, to Inspector #554, that resident #044, who resides in one of the identified room, was on an identified precautions, and indicated that there was one resident residing in the other identified room, in another precaution. PSW #100 indicated being unaware of why there was no signage on the door to either rooms, and indicated they had only been instructed to wear an identified PPE when providing care to identified residents in the two rooms, and to keep their linens separate from other resident's linens.

On an identified date, identified signage was observed on the door of one of the resident doors. Inspector #554 observed a caddy, on wheels, outside the door of the room. The caddy contained identified PPE's,but there was no eye protection available in the PPE caddy. PSW #100 was observed providing care to resident #044, PSW was not wearing PPE while in the resident room.

The identified precautions signage, on the door to an identified room, indicated that the specific PPE's were to be used.

Eye protection was not observed to be available in the PPE caddy, for staff use while providing care to resident #044, on four identified dates.

PSW #100 indicated, to Inspector #554, being aware that resident #044 was in an identified precautions.

PSW #100 indicated that signage was placed on resident's room (identified room) at some point between identified dates, indicating that no instruction was provided by registered nursing staff and/or others. PSW indicated that it was their understanding that one specific PPE was required when providing care to resident #044, but that other PPE's were optional.

RN #101 indicated, to Inspector #554, that resident #044 was and remains on an identified precautions. RN #101 indicated that there should have been signage identifying the precaution in place on the door to the room. RN #101 indicated that staff were aware that they were to follow precautionary signage on resident room doors, and were to wear the PPE's as indicated by the signage.

RN #101 indicated working on identified dates and indicated that not being told by PSW's

that there was no eye protection available for use in caring for resident #044.

RN #101 indicated that a resident residing in the identified room was on an identified precautions but that the precautions were only in place for registered nursing staff when completing an identified procedure for that resident. RN #101 indicated that there should have been signage identifying the precaution in place on the door to the room.

Interim DOC indicated, to Inspector #554, that staff are expected to follow precautionary signage posted on resident rooms, and to use identified PPE's as per signage.

During separate interviews with Inspector #554, RN #101, and Interim DOC indicated that staff receive training, specific to Infection Prevention and Control, annually.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically with regards to identification of precautionary measures to be taken, and use/application of PPE.

2. On an identified date, soiled blue gowns were observed on the carpeting in an identified hallway. Soiled towels, washcloths, and a soiled continence brief with exposed fecal matter, were observed on the floor in an identified resident room. Two PSW's were in the room providing care to a resident at the time of this observation.

PSW #100 indicated to Inspector #554, being aware that soiled linens, clothing and continence products are not to be put onto floors, but indicated it happens as there is nowhere else to place them when providing care to residents.

RN #101 indicated to Inspector #554, that staff are not to place soiled products and or linens into designated linen/clothing hampers, and or waste receptacles. RN #101 indicated that staff are not to place soiled products or linens on the floor.

Interim DOC indicated to Inspector #554, that staff are not to place clothing, linens or continence products on the floor, as this is unsanitary.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically with regards to the handling of soiled linens, clothing and continence products.

3. HSK #107 was observed on an identified date, by Inspector #623, in dining room of

home area, Housekeeper was observed by Inspector #623 to take a small garbage can from in front of the survery that contained various food items, use a gloved hand to remove the items from the garbage and place them into a larger garbage bag on the housekeeping cart. Housekeeper #107 was then observed to continue to wear the same gloves while working in the dining room, also observed to touch their face and hair with the gloved hands.

During an interview with Inspector #623, the housekeeper #107 did not seem to understand the questions when asked about infection control practices and hand hygiene.

During an interview with Inspector #623, ESM indicated that housekeeper #107 has participated in education related to infection control practices.

The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically hand hygiene and PPE's. [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 to ensure there is a process in place, and monitored ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: 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.

Pursuant to, 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: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Pursuant to, O. Reg. 79/10, s. 48 (2) - Each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

Pursuant to, 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 assistive aids.

The licensee's policy, 'Fall Prevention and Injury Reduction Program' states that Revera is committed to providing a Fall Prevention and Injury Reduction Program to reduce falls and risk of injury. The Fall Prevention and Injury Reduction Program indicates that the program is Interdisciplinary and that the program is based on clinical best practices and is in keeping with standards set by provincial and regional health and regulatory authorities. The licensee's policy directs that a fall risk screen, assessment, and plan of care are developed for each resident based on individual needs. The Fall Prevention and Injury Reduction Program, for long-term care, includes procedures for "Continuous

Review'.

The licensee's policy, 'Continuous Review' indicates that a continuous review will occur, when a resident:
- Undergoing a quarterly or annual review;
- Has experienced a significant change;
- A Fall Risk Assessment is completed by a regulated health professional following the seven-day observation period to determine any change in resident specific risk and action is to be taken accordingly. This may occur further assessments, referrals, immediate implementation of fall prevention and injury reduction strategies, team communications and collaboration, and updates to the individualized plan of care;
- Fall Risk Screen will be completed at the discretion of the Interdisciplinary Team;
- The resident's plan of care is reviewed and updated with any change and based on new information.

Related to Intake #001738-18:

The ED submitted a CIR on an identified date, with regards to an incident that causes an injury for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #047 had an identified incident a specified number of days earlier and was later transferred to hospital due to a change in health status.

The clinical health record, for resident #047 was reviewed for an identified period. Documentation, by registered nursing staff, documents that resident #047 had an identified number of falls during the identified dates, some of which resulted in injury to resident #047.

A Fall Risk Assessment (FRAT) was documented as completed on an identified date. This is the only FRAT in the clinical health record for the identified year.

RN #123 indicated to Inspector #554 that is was the policy, of the licensee, that a FRAT was to be completed for all residents quarterly, annually and with a significant change. RN #123 indicated that the FRAT was not being consistently completed by registered nursing staff, which lead the licensee to change their Fall Prevention and Injury Reduction Program.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is, complied with, specifically the FRAT, which was to be completed quarterly, annually and with a significant change as part of the Fall Prevention and Injury Reduction Program. [s. 8. (1) (b)]

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

Pursuant to, 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 assistive aids.

The licensee's policy, 'Head Injury Routine' is part of the Falls Prevention and Injury Reduction Program. The policy directs that the nurse will:
- Complete the Neurological Flow sheet, and directs that the resident is not to be moved if a head injury is suspected;
- Notify the Physician or Nurse Practitioner (NP) for further instructions (e.g. Identified drug therapy with a head injury, and emergency transfer for assessments);
- Complete Post-Fall documentation as per the Post-Fall Management procedure;
- Notify the Physician if there is a sudden change in vital signs, and/or neurological assessment, or if the resident has the following symptoms, including (but not limited to) becomes increasingly restless, irritable, or confused; new or worsened slurred speech.

The 'Head Injury Routine' policy was provided by the DOC. The DOC indicated that the policy, 'Head Injury Routine' was in place and was being followed, by registered nursing staff, during the identified period, when resident #047 was documented as having identified falls, and having had sustained injury.

Related to Intake #001738-18:

The ED submitted a CIR on an identified date, with regards to an incident that causes an injury for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #047 had an identified incident a specified number of days earlier, and was later transferred to hospital due to a change in health status.

The clinical health record, for resident #047 was reviewed for an identified period.

Documentation, by registered nursing staff, documents that resident #047 had identified falls during the identified dates, the resident sustained injury in a specific incident.

Resident #047 takes an identified medication prescribe by the physician.

On an identified date, RN #122 documented, in a progress note, that resident #047 was found by a PSW on the floor. RN #122 assessed resident #047 and documented that resident sustained specific injuries. Resident was assisted to stand, and provided care. There is no documentation that RN #122 contacted the Physician and or NP specific to the incident and injuries sustained.

RN #122 was not available for interview during this inspection.

The DOC indicated, to Inspector #554, that RN #122 should not have moved resident #047 after assessing that resident had sustained an identified injury. DOC further indicated that resident #047's physician should have been contacted for direction, noting that resident sustained injury and was prescribed an identified medication.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is, complied with, specific to falls prevention and management, for resident #047. [s. 8. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Related to Intake #017214-17:

A written complaint was received by Centralized Intake Assessment and Triage Team (CIATT) from Fenelon Court LTC Home on an identified date as well as a written response to the complainant from the former Executive Director on an identified date. The written complaint was submitted to the Executive Director of the home a specified number of days earlier.

Review of the licensee's complaint log binder identified the receipt of the written complaint on an identified date, and indicated a feed back letter was provided to the complainant a specified number of days later. The original letter as well as the response

letter written by the former Executive Director were available for review. There was no written record of the ED's internal investigation related to the written complaint available for review at the time of the inspection..

During an interview with Inspector #623, the current Executive Director (ED) indicated the written complaint that was received on an identified date, was investigated by the former Executive Director. The ED indicated that when reviewing the Complaint Management Binder for 2017, the original letter and the written response from the former ED were in the binder, but there was no written record of the internal investigation by the former ED, for that written complaint, including interviews with the complainant or staff. The ED indicated that it is the expectation of the licensee, that a Client Service Response Form (CSR) would be completed, along with a written record of any meetings, or correspondence with the complainant. A written record of the outcome of the investigation should also be kept, including details of the final response that is provided to the complainant.

The licensee has failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant. [s. 101. (2)]

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.