Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2017	2017_590554_0007	002537-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

FOSTERBROOKE
330 KING STREET WEST NEWCASTLE ON L1B 1G9

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

KELLY BURNS (554), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 06-10, and February 14-17, 2017

Resident Quality Inspection #002537-17. The following intakes were inspected concurrently with this inspection, #030146-16, 030200-16, #034806-16, #034865-16, #034990-16, #000964-17, #002310-17, #002314-17, #002247-17, and #002248-17.

Summary of Intakes:

1) #030146-16 - Complaint - maintenance issues, related to the front door alarm;
2) #030200-16 - Critical Incident Report - alleged abuse (physical) involving residents #024 toward #025;
3) #034806-16 - Complaint - allegation regarding insufficient staffing and water temperatures;
4) #034865-16 - Critical Incident Report - alleged abuse (physical) involving residents #022 towards #023;
5) #034990-16 - Critical Incident Report - alleged abuse (physical) involving staff to resident #027;
6) #000964-17 - Complaint - regarding toileting of residents;
7) #002310-17, #002314-17, #002247-17, and #002248-17 - Critical Incident Reports - missing resident for less than three hours (resident #021).

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Associate Director of Care/Behaviour Support Team Lead, Environmental Service Manager, Recreation Manager, Recreation Assistant, Resident Service Coordinator, Office Manager, RAI-Coordinator, Pharmacy Consultant, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Dietary Aide(s), Housekeeping Staff, Recreation Aide(s), President Family Council, President Resident Council, Families, and residents.

During the course of the inspection, the inspectors toured the long-term care home, observed staff to resident interactions, resident to resident interactions, dining room meal service, medication administration; reviewed clinical health records, bath and shower water temperature logs, air and water temperature audits, hot water temperature records, licensee specific investigations (related to identified intakes), specific staff training records (related to abuse and neglect prevention, and falls prevention and or management), Resident Council Meeting Minutes, Nursing and Personal Care Staffing Schedules (identified period), Plans and related memo's, bath lists; and reviewed licensee specific policies and procedures relating to, LTC Bath and Shower Guidelines, Resident Non-Abuse Program, LTC Investigation of Abuse or Neglect, LTC Disciplinary Action for Abuse or Neglect, LTC Interventions for Victims of Abuse or Neglect, Resident Non-Abuse Analysis and Education, Emergency Codes, Dementia Care Program, Dementia Care - Assessment and Care Planning, Continence Care, and Continence Care - Change of Continence.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident.

Resident #013 was admitted to the long-term care home on an identified date. Resident has a history which includes cognitive and visual impairment. On admission, registered nursing staff identified resident #013 as being at "medium" risk for falls, using the Falls Risk Assessment Tool (FRAT), due to past history of falls, use of a mobility aide and gait imbalance.

A Physiotherapy Assessment was completed on a specific date, and identified the following:
Resident #013 is adjusting well, however he/she would be at risk of falls due to visual impairment. Resident has decreased strength and balance, impaired gait with a mobility aide and other associated risk factors. Resident is full weight bearing, but requires supervision for transfers.

The clinical health record, for resident #013, was reviewed (by Inspector #554) for a six month period, indicating that resident #013 had fallen three times; dates of the falls were documented, by registered nursing staff, on specific dates. Documentation indicates that resident did not sustain injury, but was placed on increased monitoring following each fall.

The written care plan(s) for resident #013 (identified dates) were reviewed (by Inspector

#554). The review failed to provide supporting documentation as to the planned care, for resident #013, specific to falls risk, and interventions in place to mitigate further risk to resident #013.

Registered Nurse (RN) #101 and the Associate Director of Care both indicated (to Inspector #554) that noting that resident #013 was identified as being at risk for falls, (FRAT, on an identified date) and having had three falls, during a period of six months, the written care plan should have identified falls risk as a problem and that interventions should have been in place.

The written care plan was not updated to reflect the planned care, the goals the care is intended to achieve and or clear direction to staff and others who provide direct care, to resident #013, specific to falls prevention and management, until an identified date following these falls. [s. 6. (1)]

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

Related to Intake #002874-17:

Resident #026 has a history which includes cognitive impairment. Resident #026 can self-transfer and is ambulatory with the aid of a mobility device.

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on identified date, regarding an alleged incident of resident to resident physical abuse. The alleged abuse incident, involved resident #026 and resident #011. Resident #011 sustained injury during this incident.

Registered Nurse #103, the Director of Care and the Executive Director, all indicated (to Inspector #554) that resident #026 is known to exhibit responsive behaviours, specifically aggression, directed towards co-residents and staff.

The clinical health record, for resident #026, was reviewed (by Inspector #554) for a two day period. Details include the following:

- On an identified date and indicated hour – Resident #011 reported to RN #103 that he/she was punched five to six times, and hit in with a bottle by resident #026. Resident #011 sustained injury. The On-Call Manger was notified of the alleged abuse. Resident

#026 was placed on 1:1 staffing.

Registered Nurse #103 indicated (to Inspector #554) that he/she and the On-Call Manager (Executive Director) had decided that as a safety measure, resident #026 was to be placed on 1:1 until assessed by his/her physician. RN #103 indicated that this intervention, was communicated to the on-coming shift, which included registered nursing staff and non-registered staff.

Further review, of the clinical health record, for resident #026:

- On the same date, approximately eight hours later – Resident #026 was overheard speaking in his/her mother tongue, staff (Associate Director of Care and Registered Practical Nurse) entered the resident's room to find resident #026 in his/her wheelchair, and at the bedside of resident #011. Resident #011 was in bed sleeping. Associate Director of Care indicated (in his/her progress note) that resident #026 was agitated and upset that resident #011 was making noise. Resident #026 was removed from the room and taken to the lounge. Resident #011 was assessed by registered nursing staff to have no injury during this incident.

The Associate Director of Care indicated (to Inspector #554) that 1:1 staffing, for resident #026, had been put into place following the initial resident to resident abuse incident (earlier that day), and had been communicated to on-coming staff. Associate Director of Care indicated that there was no staff present, with resident #026, when he/she and a Registered Practical Nurse entered resident's room that day.

The Personal Support Worker assigned to the 1:1 assignment was unavailable for an interview during this inspection.

The Director of Care indicated (to Inspector #554) that 1:1 staffing, for resident #026, was initiated by RN #103 and the Executive Director, following the initial abuse incident, and that such had been communicated to both registered and non-registered nursing staff. Associate Director of Care and the Director of Care indicated (to Inspector #554) that during the licensee's investigation of this incident, it was determined (through interviews conducted) that the assigned 1:1 staff (Personal Support Worker) had gone on break and left resident #026 unattended, which resulted in the resident #026 being found at the beside of resident #011 on the said date. The Associate Director of Care, Director of Care and the Executive Director all indicated that staff assigned to a 1:1 assignment are to ensure that they are replaced by another staff when they leave for breaks, and or

prior to leaving their assigned shift. The Director of Care and Executive Director indicated that resident #026 should not have been left unattended by the Personal Support Worker. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident; and to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

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

The licensee's policy, LTC-Post Falls Management (#CARES-O10.02) directs the following:
- Non-registered staff will not move the resident; call for the nurse immediately and stay with the resident to provide comfort until the nurse arrives.
- The nurse will complete a thorough head to toe assessment, including all limbs and joints before any transfers take place.
- After a fall the following communication and documentation is required, the substitute decision maker (SDM) for residents unable to make their own decisions; a fall with no injury is communicated to the physician and or nurse practitioner; a fall with injury is immediately communicate to the physician and or nurse practitioner. All falls are entered into the Risk Management Module or Resident Incident Internal Report; 72 hour Pain Monitoring Sheet is initiated. Resident falls are communicated at every shifts to ensure compliance to applicable monitoring strategies and enhanced monitoring for further risk. The Nurse reviews and updates the resident's plan of care and interdisciplinary progress notes.

Related to Intake #034990-16:

The Director of Care submitted a Critical Incident (CIR) to the Director, on an identified date, for an alleged incident of staff to resident abuse. The alleged abuse/neglect incident occurred three days earlier.

Details of the alleged staff to resident abuse/neglect incident are as follows:

- Personal Support Workers (PSW) #105 and #124 heard a noise, which sounded like a resident falling in the hallway. PSWs went into the hall, observed resident #027 sitting on the floor in the hallway and heard Registered Nurse (RN) #103 arguing with resident #027, who was on the floor. Details, within the CIR, indicate that resident #027 stated that RN #103 had knocked him/her over, resulting in a fall. Director of Care indicates, in the CIR, that resident #027 was upset with RN #103, and that the RN walked away from resident #027 and left resident on the floor. Director of Care indicates, in the CIR, that RN #103 did not assess resident #027 and or provide nursing care to the resident related to the falls incident.

Personal Support Worker #105 indicated (to Inspector #554) that he/she witnessed RN #103 standing over resident #027, who was on the floor in the hallway. PSW indicated he/she did not witness RN #103 assess resident #027, but observed RN #103 walk

away, leaving resident unattended on the floor. PSW #105 indicated he/she and his/her colleague (PSW #124) were not directed by RN #103, or any other registered nursing staff, to assist resident off of the floor. PSW #105 indicated he/she and PSW #124 assisted resident #027 off the floor, post fall.

Registered Nurse #103, who was the Charge Nurse on shift (on the identified date), indicated (to Inspector #554) that he/she did recall the incident between he/she and resident #027. RN #103 indicated resident #027 was yelling and swearing at him/her following the fall. RN #103 indicated (to Inspector #554) that she/he walked away, and left resident #027 on the floor; RN #103 indicated (to Inspector #554) that he/she felt embarrassed by what resident #027's was saying, and needed to distance him/herself from the resident. RN #103 indicated (to Inspector #554) that he/she did not assess, and or provide any nursing care, to resident #027 at the time of the fall or afterwards. RN #103 indicated that he/she did not document that resident had fallen, or the incident between he/she and the resident, nor did he/she communicate the incident to the oncoming shift.

The Executive Director indicated (to Inspector #554) that resident #027 did not sustain injury as a result of the said fall. Executive Director indicated that SDM for the resident was made aware of the fall incident.

The licensee's policy, LTC-Post Falls Management (#CARES-O10.02), was not complied with as indicated above, by Personal Support Workers #105 and #124, and/or Registered Nurse #103, as resident #27 was assisted off of the floor prior to registered nursing staff assessing resident for injury; RN #103 did not assess resident #027 post fall for potential injuries, and the fall incident was not documented and or communicated to the oncoming shift. [s. 8. (1) (a),s. 8. (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 plan in place and monitored ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is, complied with, specifically Falls Prevention and Management, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee's policies, Resident Non-Abuse Program (#ADMIN1-P10-ENT) and Mandatory Reporting of Resident Abuse or Neglect (#ADMIN-O10.01), both direct that, anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift. Policy, Mandatory Reporting of Resident Abuse or Neglect further directs that mandatory reporting under LTCHA, section 24 requires a person to make an immediate report to the Director of the Ministry of Health and Long Term Care if there is reasonable suspicion that abuse or neglect occurred or may occur as well as details to support the suspicion.

Related to Intake #03499-16:

The Director of Care submitted a Critical Incident Report (CIR), on an identified date, with

regards to an alleged incident of staff to resident abuse/neglect. Details of the alleged abuse/neglect are as follows:

- Personal Support Workers (#105 and #124) heard a noise, similar to that of a resident falling in the hallway. When PSWs arrived, they saw resident #027 sitting on the floor, and heard RN #103, who was the Charge Nurse, arguing with the resident. Resident #027 indicated to RN #103 that he/she had knocked him/her (the resident) over, and caused him/her to fall to the floor. PSW #105 indicated (to Inspector #554) that he/she had heard resident #027 accusing RN #103 of knocking him/her to the floor. Registered Nurse #103 indicated (to Inspector #554) that the resident was screaming and swearing at him/her, which resulted in he/she walking away from the resident, leaving resident #027 on the floor in the hallway. Personal Support Workers indicated RN #103 did not assess the resident nor assist resident in getting off the floor. Resident #027 was later assisted off of the floor by personal support workers (#105 and #124). The alleged incident was said to have occurred on an identified date.

Personal Support Worker #105 indicated (to Inspector #554) that he/she witnessed the interaction between RN #103 and resident. PSW #105 indicated that he/she heard resident #027 stating that RN #103 had knocked him/her to the floor. PSW #105 indicated (to Inspector #554) that he/she did not report the alleged abuse/neglect incident to his/her supervisor on the identified date, as RN #103 was the Charge Nurse on shift, and directly involved with the alleged incident. PSW #105 indicated in hindsight, he/she have reported that alleged abuse/neglect incident, as there was a Registered Practical Nurse, who is also a supervisor, working within the long-term care home. PSW #105 further indicated (to Inspector #554) that staff do have access to contact information for management, specifically the Director of Care and the Executive Director. PSW #105 indicated that he/she him/herself did not notify the Ministry of Long-Term Care (MOHLTC) regarding this incident.

The Executive Director indicated (to Inspector #554) that Personal Support Worker #105 reported the alleged abuse/neglect incident involving resident #027 and RN #103 to the Director of Care and herself two days following the alleged incident. The Executive Director indicated that as of this time, PSW #124, who also witnessed the incident, had not reported this incident to them.

Personal Support Worker #124 was not available for an interview during this inspection.

Personal Support Workers #105 and #124 failed to comply with the licensee written

policies, Resident Non-Abuse Program (#ADMIN1-P10-ENT) and Mandatory Reporting of Resident Abuse or Neglect (#ADMIN-O10.01) by not immediately reporting alleged or suspected abuse or neglect to the Executive Director, or if unavailable to another supervisor on shift, nor was such reported to Director (MOHLTC).

Executive Director indicated (to Inspector #554) that all staff have been provided education specific to the licensee's Resident Non-Abuse Program. [s. 20. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person(s) who had reasonable grounds to suspect

that, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Under O. Reg. 79/10, s. 2 (1) - For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" is defined and includes, the use of physical force by a resident that causes physical injury to another resident.

Under O. Reg. 79/10, s. 5 – For the purposes of the Act and this Regulation, neglect is defined as, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern or inaction that jeopardizes the health, safety, or well-being of one or more residents.

Related to Intake #034990-16:

The (Acting) Director of Care submitted a Critical Incident Report (CIR), on an identified date, with regards to an alleged incident of staff to resident abuse/neglect. As per records reviewed by the inspector, the Director of Care had earlier communicated the alleged abuse/neglect to the after-hours contact number for the Ministry of Health and Long-Term Care (SAC #142530), this notification was made on the same date.

Details of the alleged abuse/neglect are as follows:

- Personal Support Workers (#105 and #124) heard a noise, similar to that of a resident falling in the hallway. When PSW's arrived, they saw resident #027 sitting on the floor in the hallway, and heard RN #103, who was the Charge Nurse, arguing with the resident. Resident #027 indicated to RN #103 that he/she had knocked him/her (the resident) over, and caused him/her to fall to the floor. Registered Nurse #103 indicated that resident was screaming and swearing at him/her, which resulted in RN #103 walking away from the resident, leaving resident #027 on the floor in the hallway. Personal Support Workers indicated RN #027 did not assess the resident nor assist resident in getting off the floor. Resident #027 was later assisted off of the floor by personal support workers (#105 and #124). The alleged incident was said to have occurred on an identified date (earlier than CIR submission). There is no documentation of the alleged incident in resident #027's clinical health record.

The Executive Director indicated (to Inspector #554) that she and the Acting Director of Care, were made aware of the alleged incident, by Personal Support Worker #105, two

days following the alleged incident. The Executive Director initially indicated that it was her understanding that the Director of Care did immediately report the abuse/neglect to the Director.

During a subsequent interview (same day), the Executive Director indicated it that the Director of Care may not have immediately reported the alleged staff-resident abuse/neglect to the Director as such was being investigated by management (Executive Director and the Director of Care). The Executive Director indicated awareness that abuse/neglect are to be immediately reported.

The Executive Director indicated (to Inspector #554) that the licensee's investigation concluded, disciplinary action was issued to RN #103, specifically related to the licensee's policies not being followed. The Executive Director indicated that RN #103 did not intentionally cause resident #027 to fall.

The Acting Director of Care was unavailable for interview during this inspection, as he/she is no longer employed by the long-term care home. [s. 24. (1)]

2. The license failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Intake #002874-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of resident to resident physical abuse. The alleged abuse incident, involving resident’s #011 and #026, was said to have occurred earlier that day.

The clinical health record, for resident #011, was reviewed (by Inspector #554), a progress note dated specific to the identified date, provides details of the alleged abuse incident:

- At an identified hour, Registered Nurse (RN) #103 indicated (in a progress note) that he/she heard a tapping at the door of the medication room, when he/she opened the door, he/she observed resident #011 leaning alongside the couch (in the lounge);

resident #011 appeared anxious and reported that his/her roommate (resident #026) had punched him/her five to six times while he/she slept. Resident #011 indicated (to RN #103) that he/she swung back at resident #026, striking resident him/her; resident #011 indicated he/she attempted to ring his/her call bell to call for help, and reports that resident #026 then struck him/her (resident #011) with a bottle, hitting him/her; resident #011 stated he/she kicked out at resident #026, and resident #026 then retreated to his/her bed. Resident #011 was assessed by RN #103 to have sustained injury. Resident #011 indicated being upset by the interaction.

Registered Nurse (RN) #103, who was the Charge Nurse on identified shift, indicated (to Inspector #554) that he/she had not notified the Ministry of Health and Long-Term Care (MOHLTC), as to the alleged resident to resident physical abuse incident. RN #103 indicated that registered nursing staff are directed to contact the On-Call Manager of any incidents involving abuse/neglect, and management will contact MOHLTC. RN #103 indicated that the On-Call Manager, who he/she believes was the Executive Director, was contacted at an identified hour, specifically to report the resident to resident abuse which had occurred. Registered Nurse #103 indicated (to Inspector #554) that registered nursing staff are not permitted to contact that Ministry of Health and Long Term Care (MOHLTC), and have been directed by management (Director of Care and the Executive Director) that all contact with the MOHLTC is to be by management only.

The licensee's policies, Resident Non-Abuse Program (#ADMIN1-P10-ENT) and Mandatory Reporting of Resident Abuse or Neglect (#ADMIN-O10.01), both direct that, anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift. Policy, Mandatory Reporting of Resident Abuse or Neglect further directs that mandatory reporting under LTCHA, section 24 requires a person to make an immediate report to the Director of the Ministry of Health and Long Term Care if there is reasonable suspicion that abuse or neglect occurred or may occur as well as details to support the suspicion.

The Executive Director indicated (to Inspector #554) that RN #103 had contacted her, at an approximate hour on the identified date, as to the alleged abuse involving residents #011 and #026. Executive Director indicated, she did comment to RN #103, that notification to the Director (MOHLTC) could wait until management's arrival later that day. The Executive Director indicated, that at the time of her discussion with RN #103, it was her understanding that resident #011 was not injured, so notification to MOHLTC could be delayed. Executive Director indicated that once she and the Director of Care

determined that resident #011 was injured they notified the Director by submitting a CIR.

During a secondary interview (with Inspector #554), the Executive Director indicated awareness that alleged, suspected and or witnessed abuse is to be immediately reported to the Director. Executive Director indicated that all staff are being re-educated as to this directive. [s. 24. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Intake #034806-16:

Inspector #554 during this inspection was inspecting upon a complaint with regards to resident bathing not being completed, due to insufficient staff (staffing not consistent with

the licensee staffing plan).

Resident #013 is cognitively well. Resident #013 indicated, during week one of this inspection, that he/she is scheduled to have a bath on Sunday and a shower on Wednesday. Resident #013 indicated (to Inspector #554) that he/she did not receive his/her tub bath, on Sunday (identified date) and did not receive his/her shower on the previous Wednesday. Resident #013 indicated that Personal Support Workers indicated that they were short personal support workers on their assigned shift, and could not provide his/her a bath and or shower on the identified dates. Resident #013 indicated that his/her scheduled bath and or shower had not been provided to him/her, nor had an alternate date or time been offered to him/her. Resident indicated frustration with not receiving his/her scheduled bath and or showers.

Personal Support Worker (PSW) #105, Registered Nurse (RN) #101, and #129 indicated (to Inspector #554) that baths and or showers are at times not consistently completed due to the long-term care home having insufficient staff. Personal Support Worker #105 and Registered Nurses interviewed indicated that the expectation (by nursing management) is that baths and or showers are completed on the assigned shift, and/or caught up the next day if the scheduled bathing was not completed. PSW #105, as well as RN #101 and #129 indicated that there is an alternate resident care assignment to follow, as well as a "plan of action" as to how to complete scheduled bathing and/or showers when the long-term care home is not fully staffed.

Registered Nurse #101 provided the inspector with a communication (memo, specific date indicated) which was identified as "Missed Baths" (directive written by the Director of Care); RN #101 indicated that this directive is for nursing staff to follow in the event that a resident or residents bathing is not completed on the date scheduled. RN #101 indicated that the communication includes, specific "criteria" that registered staff are to follow. The communication (dated memo) and indicated "criteria" reads as follows:

The licensee's memo was reviewed (by Inspector #554) and stated, that in order to ensure that our residents always receive two baths a week, we have devised a plan that will be followed at any time there is a missed bath. Names of the residents who did not receive a tub bath or shower on their assigned day are to be reported to the nurse on the unit forty-five minutes prior to the end of the shift. Names of residents will be recorded on a list that will be maintained by the registered nursing staff. A call in will be done for a bath shift based on the criteria outline to the registered nursing staff. It remains the expectation of the management that all tub baths and showers are completed on the day

they are assigned, by the staff working that shift. When working short, it is an expectation that staff make the effort to complete the assigned bath or shower.

The criteria, in the memo, directs, that in order to ensure that our residents always receive two baths a week, we have devised the following plan, this process is to be followed at all times. Such indicates:
- a) As soon as four (4) residents have missed a bath on any combination of shifts call in one PSW to work a four hour bath shift (1300-1700 hours). This shift will occur closest to the fourth missed bath (e.g. two baths missed on the Sunday day shift, one bath missed on the Sunday evening shift, one bath missed on the Monday day shift, call in staff for the Tuesday; or four missed baths on Monday, registered nursing staff are to call in PSW for a shift for Tuesday afternoon). Note: There is further direction for six to eight residents baths missed (similar to above direction), referenced in this memo.

Registered Nurse(s) #101 and #129 indicated (to Inspector #554) that staff call in procedure for missed baths/showers if not consistently followed as per the directive, as the long-term care home is frequently short staffed (staffing not consistent with the licensee staffing plan) and there is no one to call (PSWs) if the long-term care home is already short staffed. Both RN's indicated that management, specifically the Associate Director of Care, Director of Care and the Executive Director, are aware that residents are not being provided twice weekly bathing due to short staffing.

Registered Nurse #101 and #129 indicated that PSW's are to provide a daily list, to registered nursing staff, as to any resident's baths and or showers not completed on their assigned shifts. RN #101 and #129 both provided the inspector with a list of residents who had missed bathing during the period of approximately two months.

A clinical health record review was completed for the following residents, #028, #037, #038, #041, and #042 (randomly reviewed, based on the list provided by RN #101 and #129), specific to missed bathing, the following was documented:

Resident #028:

Resident #28 requires extensive assistance of staff for all activities of daily living (ADLs), including bathing. As per the bath list (schedule), resident is to receive bathing on Tuesday and Saturday's. Resident #028 was not provided bathing on three identified dates; documentation provides support that resident #028 was not provided twice weekly bathing for three consecutive weeks. Documentation further details that resident #028

missed his/her scheduled bathing on an identified date, during this time period resident was bathed on a specific date and his/her next shower was provided to him/her for seven days. Resident #028 is cognitively impaired and was not able to be interviewed by the inspector.

The Office Manager indicated (to Inspector #554) that the long-term care home was working short on some of the identified dates, but was fully staffed on the other date which was identified.

Personal Support Worker #105, RN #101 and #129 indicated (to Inspector #554) that when the long-term care home is short personal support workers on shifts, baths and or showers are often not completed due to time constraints, and that it is difficult to complete bathing on the next shift, so residents usually go without the missed bath and or shower. PSW #105, RN #101 and #129, all indicated that if the bath or shower was not documented such would indicate that bathing was not completed.

Resident #037:

Resident #037 requires extensive assistance of staff for all ADLs, including bathing. The bath list (schedule) indicates that resident #037 is to receive bathing on Tuesday and Saturday's. Resident #037 was provided bathing on specific dates; documentation details that resident #037 went seven to nine days between bathing, therefore did not receive twice weekly bathing. Documentation in POC (point of care, home’s electronic records) details that resident #037 was provided bathing on an identified date, and his/her next bath and her shower was provided eighteen days later. There is no documentation to suggest resident refused bathing, was absent from the home or that a bed bath was performed during this review. Resident #037 is cognitively impaired and was not able to be interviewed by the inspector.

The Director of Care indicated bathing as a "task" was inadvertently missed being entered onto the electronic daily flow sheet records, by registered nursing staff, and therefore personal support workers and others were not alerted that bathing was being missed for this resident. The Director of Care indicated that personal support workers should have been aware that resident #037 was to be bathed as the residents name was on the scheduled bathing list in the care binders, which is to be reviewed at the beginning of each shift.

Resident #038:

Resident #038 requires total assistance of staff for all ADLs, including bathing. The bath list (schedule), resident is to receive bathing on Tuesday and Friday's. As per the POC documentation, resident #038 was not provided bathing on an identified date in December 2016. During the month of January 2017, resident #038 had only one bath/shower in a ten day time period. There is no documentation to suggest resident refused bathing, was absent from the home or that a bed bath was performed during this review. Resident #038 is cognitively impaired and was not able to be interviewed by the inspector.

The Office Manager indicated (to Inspector #554) that the long-term care home was not working short during this review period.

RN #101 and #129 indicated being unsure as to why resident #038 had missed scheduled bathing as the long-term care home was not short staffed (staffing not consistent with the licensee staffing plan), but indicated that personal support workers had placed resident's name on the daily list indicating resident was not provided bathing for unknown reasons.

Resident #041:

Resident #041 is dependent on staff for all ADLs, including bathing. The bath list (schedule), resident #041 is to receive bathing on Tuesday and Friday's. As per the POC documentation, resident was not provided bathing on an identified date, and only had one bath/shower offered during this same seven day period. Documentation details that during month of January 2017, resident #041 was not provided bathing on scheduled dates and went 10 days between bathing. There is no documentation to suggest resident refused bathing, was absent from the home or that a bed bath was performed during this review. Resident #028 is cognitively impaired and was not able to be interviewed by the inspector.

The Office Manager indicated (to Inspector #554) that the long-term care home was short staffed during this time period.

RN #101 and #129, as well as Personal Support Worker #105 indicated (to Inspector #554) that if the long-term care home short staffed (staffing not consistent with the licensee staffing plan) on the assigned shift, that other resident care takes priority over bathing and that once a bath or shower is missed it is difficult to catch up (complete) the

task (bath and or shower).

Resident #042:

Resident #042 indicated (to Inspector #554) that he/she is not consistently receiving his/her twice weekly showers, and is often told by care staff that the long-term care home is working short, and they do not have time to assist him/her with his/her shower. Resident #042 indicated that missing his/her showers, leaves him/her feeling "dirty". Resident #042 indicated he/she could not provide specific dates in which his/her showers were missed, but indicating missing his/her shower "just the other night".

Resident #042 is independent with bathing, but requires the assistance of staff for transfers due to visual impairment. The bath list (schedule), resident #042 is to receive bathing on Wednesday and Saturday's. POC documentation provides details that resident was not provided twice weekly bathing during the month of January 2017. Resident went eleven days without being bathed.

The Office Manager indicated (to Inspector #554) that the long-term care home was not working short during this review period.

The Director of Care and the Executive Director indicated (to Inspector #554) that it is an expectation that residents are provided twice weekly bathing, unless resident's plan of care directs differently. Both indicated not being aware that residents are not receiving twice weekly bathing, and both indicated that they rely on Registered Nurses, who are in supervisory (charge) role, to communicate when care is deficient or lacking.

At the time of this inspection, the Director of Care was in the process of reviewing current bathing practices and was making revisions to the staffing routines, and indicated that she had a date scheduled to meet with both registered and non-registered staff with regards to resident bathing expectations. [s. 33. (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 plan in place and monitored, ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to ensure that the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

The licensee's policy, LTC-Bath and Shower Guidelines (#CARE14-O10.02) directs the following:

- Safe water temperature for staff assisted bath and shower is thirty-eight (38) degrees to

forty-three (43) degrees Celsius. Where a resident identifies a preference for a water temperature lower than thirty-eight degrees Celsius, this preference will be noted on the resident's care plan and communicated to all care providers.
- A daily water temperature check is performed and recorded before each bath of the day. At a minimum, three (3) water temperature checks are carried out before immersing resident into the tub or shower.
- Water Temperatures will be taken of both the bath and showers before giving resident a bath or a shower.
- A temperature check will be performed by turning on the water tap in the tub to hot only; determine the temperature of the water by, placing a hand held thermometer into the water stream for at least 10 seconds without interference; remove the thermometer from the water and read the temperature. Read the temperature from the integrated tub thermometer.
- Record the date, time and exact temperature of the handheld thermometer and the integrated tub thermometer on the bath/shower log in that tub room.
- The Bath/Shower Water Temperature Log will be used to record all water temperatures. Water temperatures that are outside of the acceptable range (38 degrees to 43 degrees Celsius) the identified tub or shower will be tagged-out of service, and this will be communicated to the manager.
- Maintenance will be notified of the need to recalibrate the water temperature for the tub.
- Maintenance will notify the manager once the issue has been resolved.
- Staff are to confirm the water temperature in accordance with the procedures outlined, including recording the temperature on the bath/shower temperature logs.

Related to Intake #034806-16:

During this inspection, Inspector #554 was inspecting a complaint regarding the long-term care home not having hot water on identified dates (and baths and showers not being completed).

The Bath/Shower Water Temperature Logs were reviewed (by Inspector #554) for the two resident tub/shower rooms, for the period of approximately three months with the following details documented by staff:
- there were several dates during this time period were the water temperatures were not recorded, or recorded not in a water degree, but staff using a "check mark" versus a number and a degree; there were forty-four times where the temperature of the water was recorded as being below 38 degrees with no corrective action documented. The bath water temperatures ranged from 22 degrees Celsius to 39 degrees Celsius (except

on three identified dates in December 2016 when the water temperature (of the bath) were recorded by personal support workers to be 40-41 degrees Celsius);
- there were no shower water temperatures recorded during this same time period. The Bath/Shower Water Temperature Log indicated that the shower had been used for resident bathing, as identified by residents names (initials) being recorded on said date by care staff.

Personal Support Worker (PSW) #125 indicated (to Inspector #554) that his/her role includes bathing and or showering of residents. PSW #125 indicated no awareness of what the safe water temperature range for bathing and or showering of residents was. PSW #125 indicated that if he/she believed that the water temperature was too cold or too hot (before bathing a resident), he/she would contact maintenance staff and if there was no maintenance staff in the home, he/she would contact registered nursing staff. PSW indicated that water temperatures are taken using a hand held (mercury) thermometer; PSW indicated he/she turns on the tub faucet and allows the water to run for a few moments before taking the temperature, and when the red on the thermometer stops moving (rising) he/she records the water temperature in the water temperature record binder in the tub room.

Personal Support Worker (PSW) #105 indicated (to Inspector #554) that the safe water temperature range is 38-43 degrees Celsius, as indicated on the water temperature record sheet; PSW indicated that if the water temperature taken is outside of that range they are to immediately report such to the registered nursing staff and or to maintenance staff. PSW #105 indicated that water temperature (for the tub) is taken using a hand-held thermometer. PSW #105 indicated that the initials entered onto the water temperature log, beside the water temperature, identifies the resident that was bathed at that time.

Registered Nurse (RN) #101 indicated (to Inspector #554) that the personal support workers, on each resident home area(s), take the water temperatures of the bath and shower on each shift, record the (water) temperature in the Bath/Shower Water Temperature Log (form); RN #101 indicated that the Bath/Shower Water Temperatures (form) are stored in binders in tub/shower rooms. RN #101 indicated that water temperatures not within a safe temperature range (of 38-43 degrees Celsius) are to be reported to registered staff (by personal support worker) and or to maintenance for follow up.

The Associate Director of Care (ADOC) indicated (to Inspector #554) that his/her role includes, the monitoring of the Bath/Shower Water Temperature Log(s). ADOC indicated

that he/she strives to check that the bath/shower temperatures are taken daily on all shifts and that any water temperature outside of the safe water temperature range are communicated to maintenance staff; ADOC indicated he/she strives to check daily, that temperatures are recorded, but he/she is not consistently checking recorded temperatures, due to other work priorities. ADOC indicated reviewing the Bath/Shower Water Temperature Logs, but indicated no recall of bath/shower temperatures being outside of the safe water temperature range.

The Environmental Services Manager (ESM) indicated (to Inspector #554) that the long-term care home had experienced water temperature fluctuations on three specific dates and, had plumbing problems that affected water temperatures during a weekend in December 2016, and indicated that such would have affected the water temperature of resident suites (resident rooms, bath/shower rooms); ESM indicated having no awareness of any other water temperature issues within the long-term care home. ESM indicated that he/she relies on personal support workers, registered nursing staff and or nursing managers to report any water temperatures outside of the safe water temperature range.

The licensee failed to ensure that procedures are implemented to ensure that the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius, as per the following:

The licensee's policy, LTC-Bath and Shower Guidelines (#CARE14-O10.02), is not in keeping with legislative requirements under O. Reg. 79/10, s. 90 (2) (i), which indicates that all bathtubs and showers used by residents are to be maintained at a temperature of at least 40 degrees Celsius. Staff Interviews conducted and/or documentation reviewed failed to support that procedures contained within the licensee's policy had been implemented, and or that the maintenance staff and/or the Environmental Services Manager had been notified when hot water serving bathtubs and showers used by residents were below 40 degrees Celsius. [s. 90. (2) (i)]

2. The licensee failed to ensure that procedures are developed and implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

Related to Intake #034806-16:

Inspector #554 was inspecting upon a complaint with regards to the long-term care home not having hot water on identified dates (and baths and showers not being completed).

The Environmental Services Manager (ESM) indicated (to Inspector #554) that the long-term care home does not have a computerized system to monitor the water temperatures. Environmental Services Manager indicated that water temperatures are manually monitored on all shifts, using a hand held thermometer, by the nursing department. ESM indicated water temperatures are taken as follows:

- A registered nursing staff on the night shift, takes and records the "Source" water temperature. ESM indicated the source temperature is the resident domestic hot water line (Resident DHW line) that feeds resident suites (tub, shower and resident rooms), as well at another DHW line that feeds (supplies hot water) the laundry/kitchen of the long-term care home. ESM indicated DHW line(s) are located within the maintenance room (area in the basement) of the long-term care home, which is not accessible to residents. Environmental Services Manager indicated the domestic hot water line that feeds the resident care areas should never be more than 49 degrees Celsius and not below 40 degrees Celsius; if water temperature is not within range (indicated) then the registered nursing staff who took the identified temperature are to notify the Administrator and or the Environmental Services Manager for direction.

- Personal Support Worker or registered nursing staff take and record water temperatures within the bath/shower rooms on each resident home area.

ESM provided the inspector with the home's policy, LTC-Bath and Shower Guidelines (#CARE14-O10.02) which provides direction to registered and non-registered nursing staff, but is specific to the tub/shower rooms only. ESM indicated being aware that nursing staff take water temperatures of the domestic hot water lines (servicing kitchen, and laundry room), as well as the tub/shower rooms, but was unaware of other locations where the water temperature is taken.

The water temperature monitoring records, including forms identified as, Resident and Laundry/Kitchen Domestic Hot Water Line(s), Air and Water Temperature Record and Bath and Shower Water Temperature Log were reviewed (by Inspector #554) for the period of approximately three months. Water Temperatures for the bath/shower rooms were being taken and recorded by personal support workers on days and evenings; registered nursing staff were taking and recording water temperatures within the medication rooms on days and evenings, as well as nightly temperatures were being

taken and recorded of the domestic hot water lines within the basement.

Personal Support Worker (PSW) #105 indicated (to Inspector #554) that PSWs only take water temperatures within the bath/shower room; PSW indicated the bath/shower room is only accessible to residents when staff are in attendance.

Registered Nurse #101, Registered Practical Nurse #107 and the Associate Director of Care all indicated (to Inspector #554) that water temperatures were not being monitored in random locations, and that the only water temperatures being recorded were DHW lines (basement), in the bath/shower rooms and in the medication rooms, all of which are not areas accessible to residents, without staff in attendance.

The licensee failed to ensure that the policy regarding water temperatures being monitored once per shift in random locations where residents have access to hot water, was implemented. [s. 90. (2) (k)]

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 plan in place and monitored, ensuring that procedures are developed and implemented to ensure that the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; and hat procedures are developed and implemented to ensure that, if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff were provided training in Falls Prevention and Management.

Under LTCHA, s. 76 (7) 6 - Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations, any other areas provided for in the regulations.

Under O. Reg. 79/10, s. 221 (2) - The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following, subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

Concurrent with the Resident Quality Inspection, the inspector, reviewed and inspected a Critical Incident Report (CIR) which was submitted by the Director of Care, on an identified date. The CIR provided details related to a falls incident, involving a resident (#027), and alleged lack of action taken by Registered Nurse (RN) #103 post fall.

Executive Director indicated (to Inspector #554) that RN #103 had not had training in Falls Prevention and Management in 2016, and that RN #103 had last received the identified training in December 2015. The Executive Director indicated (to Inspector #554) that two other registered nursing staff (one RN and one Registered Practical Nurse) had also not received the above training in 2016.

During a subsequent interview (with Inspector #554), the Executive Director indicated that Personal Support Workers, who are direct care staff within the long-term care home, are not provided annual training specific to Falls Prevention and Management. The Executive Director was unable to provide statistics as to when Personal Support Workers were last provided Falls Prevention and Management training.

The licensee failed to ensure that all direct care staff were provided annual training in Falls Prevention and Management. [s. 221. (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, ensuring that all direct care staff were provided training in Falls Prevention and Management, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the admission care plan for a resident included, at a minimum, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Resident #013 was admitted to the long-term care home on an identified date. Resident has a history which includes cognitive and visual impairments. Resident #013 walks utilizing a mobility device.

On admission, Resident #013 was assessed by registered nursing staff as being at risk for falls. Registered Nursing Staff completed a Falls Risk Assessment Tool (FRAT, completed on identified date) which identified resident #013 as being at "medium" risk for falls, due to past history of falls, use of a mobility aide and gait imbalance.

The admission care plan, which was initiated, by registered nursing staff, on an identified date was reviewed by the Inspector #554, the documentation failed to provide support that Falls risk was identified as an area of focus, nor was there documentation supporting that interventions were put into place to mitigate the identified risk, specific to falls, for resident #013.

Registered Nurse (RN) #101 and the Associate Director of Care, both indicated (to Inspector #554) that the admission care plan should have included a falls focus, as well as interventions to prevent falls, specific to resident #013.

Director of Care, as well as the Executive Director, both indicated identified risk, or potential risk to the resident or others should be documented in the care plan, especially when such was identified in the FRAT. [s. 24. (2) 1.]

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 the strategies for resident #021 related to the responsive behaviour of the resident leaving the Long-Term Care Home (LTCH) were implemented and that actions were taken to respond to the needs of the resident including assessments, reassessments and documentation of the resident's response to the interventions.

Inspector #601 reviewed four Critical Incident Reports (CIR) related to resident #021 leaving the LTCH.

Related to Intake #002247-17:

Critical Incident Report (CIR) indicated that on an identified date, resident #021 reported he/she was going outside. According to the CIR a member of the community found resident #021 off of the long-term care home's property and had returned the resident to the facility with no injury at an identified hour.

Related to Intake #002248-17:

CIR (another) indicated that on another identified date, resident #021 was off of the long-term care home's property and the ADOC found the resident at the bus stop. The CIR indicated that the ADOC brought the resident back to the home with no injury.

Related to Intake #002310-17:

CIR (another) indicated that on an identified date, resident #021 was observed walking downtown. According to the CIR, resident #021 returned to the facility approximately an hour and a half later with no injury.

Related to Intake #002314-17:

CIR (another) indicated that on an identified date, RN #101 received a call from a community member that resident #021 was walking downtown. The CIR indicated that RN #101 had walked to the edge of the property and witnessed the resident walking on the sidewalk. According to the CIR, RN #101 had called out to resident #021 and the resident did not answer or turn around. The CIR indicated that resident #021 returned to the home at a later time with no injury.

Resident #021's clinical health records were reviewed by Inspector #601 and identified that resident #021 was admitted to the home on an identified date with a history of cognitive impairment.

During an interview, the ADOC indicated to Inspector #601 that resident #021 had been transferred to a community support program and returned to the LTCH approximately two months later. According to the ADOC, the community support program had recommended that resident #021 not be able to leave the property unaccompanied due to the resident's history.

Review of resident #021's Physician Orders for a period of approximately six months indicated that resident #021 was not to leave the facility unless accompanied by staff.

Review of resident #021's written plan of care in place at the time of the four incidents involving resident #021 leaving the LTCH unaccompanied. Resident #021 had behaviour interventions developed as recommended by the community support program. The interventions included that resident #021 would not receive his/her scheduled intervention if he/she left the premises; apply medication patch daily; if resident #021 does not elope as a reward he/she received a specific beverage; resident #021 may only leave the premises with identified staff.

During an interview, RN #120 indicated to Inspector #601 that there was a time when resident #021 was to be accompanied by staff when leaving the LTCH but was not sure of the time frame. RN #120 indicated that resident #021 would go outside and would leave the property without informing staff. RN #120 indicated that resident #021 would

return to the LTCH and tell staff that he/she had been out. RN #120 indicated that it was hard to track resident's whereabouts because he/she would come and go all the time.

During an interview, resident #021 indicated to Inspector #601 that sometimes he/she didn't need the medication patch and he/she would remove the patch. Resident #021 also indicated that he/she likes to go outside and sometimes he/she goes to town for something to do.

During an interview, RN #129 and RPN #119 indicated to Inspector #601 that resident #021 was removing the medication patch and locating the patch was not always possible. RN #129 and RPN #119 also indicated that no further actions had been taken to determine the reason resident #021 was removing the medication patch.

On an identified date, the Assistant Director of Care (ADOC) documented in the progress notes that resident #021 had expressed concerns that he/she was not happy in the home because of the lack of programs. The ADOC documented that the Recreation Manager (RM) would meet with resident #021 to create a schedule of programs that would be of interest to resident #021.

Review of resident #021's clinical records (specific date) indicated that the community support program had made recommendations to develop an in-house activity program to reduce boredom and to allow resident #021 increased opportunity to get out into the community. When resident was anxious and upset staff need to ask the resident if something happened to upset him/her rather than putting the responsibility on the resident.

During an interview, the ADOC and the RM indicated to Inspector #601 that resident #021 continued to leave the LTCH despite the implementation of the behaviour interventions developed by the community support program. The ADOC and RM indicated that no further action was taken when resident #021 continued to leave the LTCH. The RM also indicated that he/she did not meet with resident #021 to discuss programs of interest and specific recreational programs were not developed to meet his/her interests.

The strategies developed and implemented for resident #021 related to the resident leaving the LTCH and the use of the identified medication patch were identified as not being effective. Resident #021's continued to remove the medication patch, leave the LTCH property and actions were not taken to respond to the needs of the resident

including assessments, reassessments and interventions. [s. 53. (4) (c)]

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

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of resident #021 who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

Inspector #601 reviewed four Critical Incident Reports (CIR) related to resident #021 leaving the facility without authorization. According to the four intakes, resident #021 had a history of leaving the property without authorization.

During an interview, the Associate Director of Care (ADOC) indicated that resident #021 had been transferred to a community support program on an identified date and returned approximately two months later. According to the ADOC, the community support program had recommended that resident #021 not be able to leave the property unaccompanied due to the resident's history.

Review of resident #021's Physician Orders for a period of six months indicated that resident #021 was not to leave the facility unless accompanied by staff.

Inspector #601 reviewed resident #021's progress notes for a period of approximately six months, and identified that resident #021 had left the property unaccompanied on seven documented occasions. Resident #021's progress notes indicated that on:

- On an identified date, RN #101 documented that resident #021 had left the property for

approximately one hour without informing staff.
- On another identified date, RPN #124 documented that resident #021 had left the property at an approximate hour and that a person in a pick-up truck had returned the resident to the property.
- On an identified date, RN #125 documented that resident #021 was witnessed standing at the bus stop earlier in the shift by a visitor and the resident was asking co-residents for money. The licensee is unaware of the time period in which resident #021 was absent from the long-term care home.
- On an identified date, RPN #124 documented receiving a call from RPN #126 indicating that resident #021 was at a bus stop in town. According to the progress note, RPN #124 notified management at an identified hour and resident #021 was escorted back to the home by the Office Manager. Time period in which resident #021 was absent from the long-term care home is unknown.
- On an identified date, RPN #124 documented that at approximate hour a family member had reported that resident #021 was seen at a bus stop on the highway. On the same date, approximately 45 minutes later, the ADOC documented that resident #021 was observed walking back into the parking lot. The ADOC's progress note indicated that resident #021 had admitted to leaving the property.
- On an identified date, RN #128 documented that the recreation centre had called and resident #021 was sitting in the pool area. RN #128 documented that the caller was asked to inform the resident to return immediately as he/she was not to leave the property. The progress note indicated that resident #021 arrived back on the property a few minutes later.
- On an identified date, RN #128 documented that a PSW saw resident #021 walking downtown. The licensee is unaware of the time period in which resident #021 was absent from the long-term care home.

During an interview, the ADOC indicated that resident #021 had been leaving the property and members of the public had called to inform the staff. The ADOC also indicated that the Director had not been notified of each occurrence of resident #021 who was missing for less than three hours and who returned to the home with no injury. [s. 107. (3) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug is destroyed, the drug was altered or denatured to such an extent that its consumption is rendered impossible or improbable.

Related to Intake(s) #002247-17, #002248-17, #002310-17 and #002314-17:

Resident #021's clinical health records were reviewed by Inspector #601 and identified that resident #021 was admitted to the home on an identified date with long-standing health history.

Inspector #601 reviewed resident #021's Physician orders for a period of six months, and identified that resident #021's transdermal medication patch (identified medication) was to be removed every morning prior to the application of the new patch.

Inspector #601 reviewed resident #021's progress notes for a six month period, and identified that resident #021's medication patch was not located on the resident by the nurse for drug destruction during specific dates during this same review period.

During an interview, resident #021 indicated to Inspector #601 that sometimes he/she will remove his/her medication patch and throw the patch into the garbage.

During an interview, RN #129 indicated that resident #021 was able to remove the medication patch and locating the patch was not always possible.

During an interview, RPN #119 indicated that resident #021's medication patch was missing in the morning (identified date). RPN #119 also indicated that resident #021's medication patch was not a controlled substance and was discarded into the regular garbage.

During an interview, RPN #107 indicated that resident #021's medication patch was

discarded into the sharps container.

During an interview, the DOC indicated to Inspector #601 that he/she was not aware that resident #021 had been removing his/her medication patch. The DOC also indicated that when resident #021's medication patch was removed by the nurses, the patch should be discarded into the white plastic containers used for drug destruction. The DOC indicated that the drugs discarded in the white plastic containers are altered to such an extent that its consumption was rendered impossible or improbable.

Resident #021 medication patch was not located for drug destruction on fifteen occasions during the six month review period. RPN #107 and RPN #119 also indicated that they were not discarding resident #021's medication patch in the white plastic container used for drug destruction. [s. 136. (6)]

Issued on this 15th day of May, 2017

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

Original report signed by the inspector.