Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 01, 2018;	2018_621547_0019 (A2)	007094-18	Resident Quality Inspection

Licensee/Titulaire de permis

Genesis Gardens Inc.
1004 Buckskin Way Orleans ON K1C 2Y6

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

Foyer St-Viateur Nursing Home
1003 Limoges Road South Limoges ON K0A 2M0

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

Amended by LYNE DUCHESNE (117) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The home's Administrator requested an extension for the compliance order #001 due date to accommodate staff education and policy review and synthesis. The new compliance due date is of September 14, 2018.

Issued on this 1 day of August 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 01, 2018;	2018_621547_0019 (A2)	007094-18	Resident Quality Inspection

Licensee/Titulaire de permis

Genesis Gardens Inc.
1004 Buckskin Way Orleans ON K1C 2Y6

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

Foyer St-Viateur Nursing Home
1003 Limoges Road South Limoges ON K0A 2M0

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

Amended by LYNE DUCHESNE (117) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 10, 11, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 2018

The following critical incident reports were inspected concurrently during this inspection:

Log #003600-17, CIS#2746-000003-17 and Log #000380-17, CIS#2746-000001-17 and Log #029715-17, CIS#2746-000017-17 and Log #002035-18, CIS#2746-000001-18 were related to resident falls;

Log #005053-17, CIS#2746-000005-17 was related to resident to resident altercation with injury;

Log #007813-17, CIS#2746-000008-17 related to an unexpected death of a resident;

Log #011942-17, CIS#2746-000013-17 and Log #005719-18, CIS#2746-000010-18 related to injuries to residents for unknown reasons;

Log #003530-18, CIS#2746-000002-18 related to alleged staff to resident abuse;

The following complaint was inspected concurrently during this inspection:

Log#020096-17 was related to concerns related to a resident's fall and the quality of food in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Activity Director, Maintenance Supervisor, Office Manager, Nutritional Manager (NM), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Restorative Care PSW, a Housekeeper, a Cook, Food Service Workers, Residents and Family Members.

In addition, the inspectors reviewed resident health care records, food production documents including planned menus, Resident Council minutes, Family Council minutes, documents related to the home's investigations into critical incidents submitted by the Licensee and policies and procedures related to Resident Abuse, Critical Incident reporting, Skin and Wound, Falls and Medication Incidents. The inspectors observed the delivery of resident care and services and staff to resident as well as resident to resident interactions. The inspectors reviewed medication administration and storage areas and observed meal services. The inspector also reviewed internal investigation documents, employee training information, employee schedules, work assignments and employee records relevant to this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 was protected from sexual abuse.

According to Ontario Regulation 79/10 "sexual abuse" means: any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident.

This inspection is related to Log #003530-18.

On a specified date, a Critical Incident Report (CIR) was submitted by the Licensee regarding a witnessed incident of staff to resident sexual abuse that occurred four days earlier. It was documented in this CIR that Personal Support Worker (PSW) #120 observed PSW #122 inappropriately touch resident #012 to a specified body part while saying "What is this?".

The Licensee's internal investigation documents were reviewed by Inspector #592. The Licensee's documentation revealed that PSW #120 witnessed PSW #122 inappropriately touching resident #012's specified body part and that resident #012 told PSW #120 and #122 "I don't like that when this person does that".

Over the course of this inspection, Inspector #592 and #547 interviewed PSW #120, who indicated having witnessed the incident of staff to resident sexual abuse of resident #012 on this specified date at the beginning of the evening shift. PSW #120 indicated not having reported this incident to any immediate supervisor as required until three days after the incident occurred upon arrival to work for the evening shift. PSW#120 reported to Registered Practical Nurse (RPN) #124 of this incident that occurred on the evening of this specified date and then they both went to report this incident to the DOC and ADOC. PSW #120 indicated having discussed this incident with PSW #121, #123 and #128 on the evening of this incident. PSW #120 further indicated that the resident does have memory problems, but is able to communicate at the present moment the residents likes and dislikes and with those comments, that is when PSW #120 realized that this was wrong. The home's Assistant Director of Care (ADOC) indicated to Inspector #592 and #547 that PSW #122 continued to work in the home on this specified date as well as the next evening assigned to care for resident #012 as the licensee was not made aware of this incident until three days later.

As such, resident #012 was not protected from sexual abuse by PSW #122 when:

A. PSWs #120, #121, #123, #128 failed to immediately report the incident of staff to resident sexual abuse from a specified date to the Licensee and the Director, allowing the alleged abuser on the nursing units on this specified date and the next

evening shift without additional precautions taken to protect resident #012 or others on the nursing units;

B. Upon being made aware of the witnessed incident of staff to resident abuse three days after the incident occurred, the Licensee did not immediately investigate or report to the Director the incident of staff to resident abuse as required by legislation and the Licensee's policy titled "Resident Abuse" as identified in WN #9, #10 and #11; and

C. The Licensee failed to immediately report the witnessed incident of staff to resident sexual abuse to the police and the resident's Substitute Decision Maker (SDM) once the Licensee was notified of this incident on the specified date, three days after the incident occurred as identified in WN #12 and #13. [s. 19. (1)]

2. The licensee has failed to ensure that resident #034 was protected from physical abuse.

According to Ontario Regulation 79/10 “physical abuse” means: the use of physical force by anyone other than a resident that causes physical injury or pain, subject to subsection (2), whereby physical abuse does not include the use of force that is appropriate to the provision of care or assisting of a resident with activities of daily living, unless the force used is excessive in the resident’s circumstances.

This inspection is related to Log #005719-18.

On a specified date, the Director of Care (DOC) reported a Critical Incident Report (CIR) regarding an incident that caused a significant injury to resident #034 on a specified area that was identified by registered nursing staff five days earlier. The Licensee did not begin any investigation into this injury until four days after the injury was identified when resident #034 was demonstrating significant pain and discomfort related to this injury. The ADOC indicated during this inspection to Inspector #547 that this significant injury for resident #034 was determined to have been a result care provided by the nursing staff as there was no recorded falls for this resident, who is dependent for all care by nursing staff and requires mechanical lift for transfers.

As such, resident #034 was not protected from physical abuse as per the following:

A. Upon being made aware of resident #034’s significant injury on a specified date,

the Licensee did not immediately investigate this injury until four days later when resident #034 was demonstrating increased pain and discomfort as identified in WN #8;

B. Upon being made aware of resident #034's significant injury and pain on a specified date, the Licensee did not report to the Director the incident of significant injury to the resident's specified body part for suspected physical abuse as required by legislation and the Licensee's policy titled "Resident Abuse" as identified in WN#10; and

C. The Licensee failed to immediately report the suspected incident physical abuse to the police and the resident's Substitute Decision Maker (SDM) as identified in WN #11 and #12. [s. 19. (1)]

3. The licensee has failed to ensure that resident #032 was protected from physical abuse.

According to Ontario Regulation 79/10 "physical abuse" means: the use of physical force by anyone other than a resident that causes physical injury or pain, subject to subsection (2), whereby physical abuse does not include the use of force that is appropriate to the provision of care or assisting of a resident with activities of daily living, unless the force used is excessive in the resident's circumstances.

This inspection is related to Log #011942-17.

On a specified date, the Assistant Director of Care (ADOC) reported a Critical Incident Report (CIR) regarding an incident that caused an injury to resident #032 that occurred two days earlier. The home began an immediate investigation into this incident regarding possible physical abuse towards resident #032 as no recorded falls for this resident, who is dependent for all care and requires mechanical lift for transfers.

The Licensee's internal investigation documents were reviewed by Inspector #547. The Licensee's documentation revealed the DOC and ADOC were unable to identify how resident #032 could have sustained this significant injury. Interviews with the DOC and ADOC with Inspector #547 identified that resident #032's injury must have been a care related injury by nursing staff.

As such, resident #032 was not protected from physical abuse as per the following:

A. Upon being made aware of the resident #032's significant injury and pain on a specified date, the Licensee did not report to the Director the incident of significant injury and pain for suspected physical abuse as required by legislation and the Licensee's policy titled "Resident Abuse" as identified in WN#8 and #10; and

B. The Licensee failed to immediately report the suspected incident physical abuse to the police and the resident's Substitute Decision Maker (SDM) as identified in WN #11 and #12. [s. 19. (1)]

Additional Required Actions:

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

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

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

s. 6. (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 the care set out in the plan of care for resident #030 was provided to the resident as specified in the plan.

This inspection is related to Log #007813-17.

A Critical Incident Report (CIR) was submitted by the Licensee on a specified date,

related to the unexpected and sudden death of resident #030 four days earlier while eating a specified item which caused the resident to choke.

Inspector #592 reviewed resident #030's health care records which indicated the resident was admitted the day before this incident with several medical diagnoses including a specified diagnosis related to difficulty swallowing. The hospital discharge information for swallowing completed the day prior to admission to the Long-Term Care home provided specific diet recommendations and interventions.

Inspector #592 reviewed the Licensee's initial Admission Nursing Assessment and 24 Hour Care Plan that indicated resident #030 required one person assistance for eating with close supervision, related to coughing and risk of aspiration.

Inspector #592 reviewed the home's Unit Daily Record for the specified admission date and the following day of the incident. The Unit Daily Record dated for the evening shift of the date of admission, indicated that resident #030 was newly admitted and was to be seated at a specific table with close supervision required by nursing staff. The Unit Daily Record indicated that nursing staff were to ensure that the resident ate slowly and swallowed food before taking another spoonful.

During this inspection, Inspector #592 interviewed Personal Support Workers (PSWs) #115 and #116, who indicated that when a resident is admitted to the home, all the information regarding nutritional needs and level of assistance required on a specific form which is made available for all nursing staff members. Both PSWs also indicated that all information is to be communicated on the 24 hour nursing report (Unit Daily Record) at each change of shift for several days until the staff know the resident. The PSW's further indicated if they were unsure about care needs, they were instructed to refer to the registered nursing staff for guidance. PSW #115 who was present during the incident involving resident #030 indicated to the Inspector not being assigned to assist the resident at breakfast time when the incident occurred, however indicated that resident #030 was heard coughing and that the PSW who was present at the table with the resident had called for help. PSW #115 further indicated that resident #030 was identified as being at high risk for choking as the resident was eating very fast and that the staff needed to slow the resident down after each bite. PSW #115 indicated that the resident was sitting at a table with the presence of a PSW at all times, however did not recall which PSW was assigned to the resident on that day. PSW #115 further indicated that all PSWs were made aware by the RN at the 0600 hours morning report on this specified date after the resident's admission regarding resident #030

specific diet recommendations and interventions.

PSW #117 indicated to Inspector #592 to be assigned resident #030's table at breakfast time when the incident occurred on a specified date. PSW #117 indicated that resident #030 was eating with no assistance and was sitting at this table in order to be provided with some supervision while the PSW was feeding other residents at the same table. PSW #117 indicated that resident #030 was sitting in a wheelchair on the opposite side of the table. PSW #117 indicated that another PSW had provided some instructions about resident #030 potential to choke and that PSWs were to monitor the resident. PSW #117 indicated that resident #030 had been served a specified food item by the kitchen staff and was observed to be eating very fast. PSW #117 indicated that approximately two minutes later, resident #030 started coughing and the nurse was immediately called. PSW #117 indicated not being aware of any other interventions at that time specifically for resident #030. Inspector #592 inquired about how the PSWs are made aware of the specific nutritional needs for newly admitted residents. PSW #117 further indicated that usually, the PSWs will refer to the kitchen staff before they serve the resident for any specific diet or recommendations. PSW #117 indicated on this specified date, the residents were served these specific food items in the morning by the kitchen staff, and did not need to verify with the kitchen staff for resident #030 diet.

The Director of Care (DOC) and the Assistant Director of Care (ADOC) indicated to Inspector #592 that the information for nutritional needs for resident #030 was communicated at the morning report. The DOC and the ADOC indicated that PSW #117 did not provide the care set out in the plan of care to resident #030 related to nutritional needs as specified in the resident's plan of care.

2. Resident # 031 was identified by the DOC and the ADOC to be at high risk for choking and to have specific nutritional interventions in place to prevent choking.

A review of resident #031's health care records was completed by Inspector #592 which indicated that resident #031 was admitted on a specified date,with several medical diagnoses. According to the most recent assessment provided by the Speech Language Therapist completed on a specified date, resident #031 required total assistance of staff with feeding as the resident had the tendency to hold food in the mouth when eating. Resident #031 was assessed as being able to swallow adequately when given verbal cues to swallow by staff. Several recommendations were documented in the resident's written plan of care.

On a specified date during this inspection, Inspector #592 observed a food service worker distribute beverages in the dining room for the breakfast meal service and then poured honey texture fluids in three regular plastic glasses. Inspector #592 observed these three regular plastic glasses on a resident's table, one with water, another with milk and a third one with orange juice. A plastic container labelled thickener was also observed beside these three plastic glasses. PSW #106 indicated to Inspector #592 that the thickener powder was required for resident #031. This thickener powder is to be added by the nursing staff to make the honey textured fluid to a pudding consistency for the resident so that the fluid should not drip from the spoon. PSW #106 further indicated that resident #031 forgets to swallow and the staff have to cue the resident to swallow after each bite.

Inspector #592 observed Registered Nurse (RN) #102 sit beside resident #031 for this breakfast meal service, while the food services staff served the resident a specified food item. Inspector #592 observed RN #102 taking the glass of milk and stirring it with a spoon without adding any thickener powder. RN #102 turned towards the resident to provide the glass of milk when RN #102 was stopped by PSW #106 who indicated that the RN needed to add some thickener powder to the glass in order to thicken the fluid to a pudding consistency. RN #102 proceeded to add some thickener powder to the glass of milk and stirring the glass of milk with a spoon and then proceeded to give resident #031 a teaspoon of milk. Inspector #592 observed that the milk was not a pudding consistency, as the milk was observed dropping from the spoon. Inspector #592 approached resident #031's table and RN #102 had already provided resident #031with the spoonful of milk and milk was observed leaking out from the resident's mouth. Inspector #592 asked RN #102 what texture and consistency was being provided to resident #031. RN #102 indicated that the texture prepared for resident #031 was appropriate as there was no jelly thickener available that morning, therefore was using the powder thickener which was not the same and was not the same consistency. Inspector #592 asked if RN #102 was aware of the detailed description for the requirement for pudding consistency for fluids that should not drop from the spoon. RN #102 showed Inspector #592 the texture which was dropping from the spoon and said that it was the proper texture. RN #102 then consulted with PSW #112 who was the regular PSW assigned to resident #031 who did not yet join the table and was informed by PSW #112 that the consistency was not appropriate for resident #031 as it was too liquid and PSW #112 was observed pushing away the two other glasses which contained water and orange juice. PSW #112 was observed adding thickener powder to the glass of milk until the milk texture was no longer dripping

from the spoon. RN #102 indicated to Inspector #592 of being aware of resident #031's fluid consistency as the RN had been involved with the resident and the Speech Language Therapist, however the RN indicated that due to not having the jelly thickener, it was hard to have the right texture for the resident that morning.

On a specified date, the ADOC indicated to Inspector #592 that the instructions were very descriptive and clear for the specific nutritional interventions to be provided to resident #031. The ADOC indicated that time was taken during the consultation with the Speech Language Therapist to ensure that all the specific requirements such as the description of the pudding texture was clear for all the staff members who were taking care of resident #031. The ADOC further indicated that resident #031 nutritional needs were not provided as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 8 (1) (b) in that the home did not ensure that any policy and procedure instituted or otherwise put in place is complied with.

As per O.Reg 79/10 s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: Skin and Wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O.Reg. s.30(1)1. general requirements for each organized program such as the Skin and Wound care program must have relevant policies and procedures.

The home's Skin and Wound Policy revised February 13, 2008 was provided by the DOC and reviewed by Inspector #592 and the following requirements were documented:

Procedure:

3. Any noted pressure ulcers will be "staged" and recorded on the "Weekly Leg Ulcer Assessment/Progress Tool if ulcer is on the leg, or on the "Weekly Ulcer Assessment/ Progress Tool if ulcer on the body. All other noted skin problems or lesions will be recorded on the "Skin Care Management-Treatment and Observations Record"

5. Registered staff will reassess all noted skin problems a minimum of once a week and record progress on appropriate form as indicated above. The progress of all pressure ulcers will be measures using the Pressure ulcer scale for healing (PUSH) Tool in combination with the pressure ulcer healing chart.

The home's Skin and Wound Policy also contained another page titled " Wound Care" revised March 04, 2008 which was revised by Inspector #592 and the following requirements were documented:

4. Each resident who exhibits skin breakdown and/or wound shall be assessed every week (Wednesday) and prn, by a member of the registered nursing staff and observations will be documented on the "Ulcer Assessment" or " Skin Care

Management" form as appropriate. This documentation will include a description of the area, including color, size, depth, location, extent of any drainage, condition of the wound area and the surrounding area.

Resident #019 was identified with a specified pressure ulcer on a specified date and was referred to the wound care specialist.

Resident #019 was seen by the wound care specialist two days later and the wound measurements indicated that the length of the wound was at 3 cm by 1.5 cm width and a specific treatment was to be provided to the resident.

As of a specified date, approximately five months later, resident #019 still requires treatment as per the physician orders and the wound care specialist as the pressure ulcer has not healed.

In a review of the Skin Care Management-Treatment and Observation Record use by the registered staff for providing treatment to the residents, the form indicated to do weekly follow-up assessment notes on a specified day of the week. The form also indicated that the weekly documentation of skin care assessment will include a description of the affected area: color, size, depth, location, drainage (color, odor) condition of the wound and surrounding area. The form also contained a column for weekly assessment documentation.

In a review of the Skin Care Management-Treatment and Observation Record for resident #019 since this specified start date, there was no size and no depth documentation found for the resident's specified pressure ulcer.

Further review was done with two other residents with skin and wound care issues;

Resident #027 was identified with pressure ulcers to specified areas. In a review of the Skin Care Management-Treatment and Observation Record from a specified four month period, inspector #592 was unable to find any documentation of the actual size and depth of both pressure ulcers.

Resident #028 was identified with pressure ulcers to specified areas. In a review of the Skin Care Management-Treatment and Observation Record from a specified four month period, inspector #592 was unable to find any documentation of the actual size and depth of both pressure ulcers.

On a specified date, in an interview with RN #102, the RN indicated to Inspector #592 that the form used for any altered skin integrity for the residents was the "Skin Care Management-Treatment and observation Record". RN #102 further indicated that measurements and assessments of wounds were done every week on a specified day by the RN or the RPN. When Inspector inquired about the measurements and staging for resident #019, the RN reviewed the current Skin Care Management-Treatment and Observation Record for the resident and indicated not knowing if it was required anymore as it was not completed for resident #019. RN #102 further indicated that if the resident's wounds were getting better there was no need to measure them, however if they were not getting better, then the registered nursing staff would measure them. RN #102 was not aware of any other forms used specifically by the home for pressure ulcers.

RN #104 indicated to Inspector #592 on a specified date of not being aware of the wound size and depth for resident #019, #027 and #028 as the registered nursing staff were not measuring the wounds as it was done by the wound care specialist. RN #104 was not aware of any other forms used specifically by the home for pressure ulcers.

The DOC indicated to Inspector #592 that the registered nursing staff were to perform a weekly wound assessment for each resident identified with altered skin integrity as per the home's policy but indicated that it was not performed at this present time. The DOC further indicated that for all residents identified with pressure ulcers, a specific form titled "weekly leg ulcer assessment/progress tool" should be used but was not yet implemented. The DOC indicated that there was another form to use for pressure ulcers which was titled "Pressure Ulcer Scale for Healing (PUSH) Tool" in combination with the "Pressure Ulcer Healing Chart", however they were not used at this present time. The DOC indicated that the home is using the Skin Care Management-Treatment and Observation Record form at this current time for all type of altered skin integrity which is usually used only for skin problems or lesions. The DOC confirmed that the policy was not followed and that the home was actively working on it.

Therefore the home did not ensure that pressure ulcers are staged and recorded on the "Weekly Leg Ulcer Assessment/Progress Tool" on a weekly basis and as well not measured using the "Pressure ulcer scale for healing (PUSH) Tool" in combination with the "Pressure ulcer healing chart". In addition, the home did not ensure that a description of the pressure ulcer such as size and depth was

completed. [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 that the Skin and Wound policy and procedure is complied by nursing staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On a specified date, a written concern letter was provided to the Licensee regarding resident #010's verbally disruptive behaviours affecting residents in the home. This letter was written by the President of the Residents' Council and co-signed by 16 other residents in the home.

On a specified date, the President of Residents' Council indicated to Inspector #547 that the Resident's Council had not received any written response from the Licensee about the complaint letter made 11 days earlier.

The Director of Care(DOC) indicated they received the written complaint letter from the President of Residents' Council on a specified date however no written response had been provided to the Resident's Council, as the DOC documented the verbal response made to the complainant on the same day of this complaint in the resident's progress notes. The DOC indicated a response was not provided to the Residents' Council to date. [s. 57. (2)]

2. On a specified date, the Residents' Council Minutes for a specified six month period were reviewed by Inspector #592. Concerns were identified and brought forward by the Resident Council as follows:

On a specified date, related to some residents being worried due to poor supervision on evenings in the front lounge. A written response was found under a form titled "Multidisciplinary referral" to the attention of the DOC indicating that the home is still looking for students, however no solution, no date and no signature of the person responding to the concerns was found.

On another specified date, related to some residents complaining that "too much perfume". A "Multidisciplinary referral" was found to the attention of the DOC, however no written responses was documented/found.

On a third specified date, related to some residents complaining that there is too much noise in the front lounge dining room, especially when other residents have visitors. A note was found beside the concerns indicating "Inform Administrator" no written response was found. A "Multidisciplinary referral" was found with the concern brought forward to the DOC and the Administrator, however no written response was documented/found.

During this inspection, in an interview with the Director of Activity (DOA) who is the appointed assistant to the Resident's Council, the DOA confirmed that the above comments/complaints were brought forward during the Resident Council Committees. The DOA indicated that following the meeting, a form titled "Multidisciplinary referral" will be given to each head department involved with the concerns, with the specific complaints/issues raised during the meeting. The DOA showed the form to the Inspector which contained a section for the head department to write a written response with the date that the form was given and the due date of the written responses. The DOA further indicated that following the meeting, on the same day, the form is distributed to the responsible department

heads. The DOA also indicated that often there will be no written response within the 10 days and that a follow-up will be done individually over and over with each department head and often no answers will be provided back to the Residents' Council.

The DOC confirmed being aware of the concerns brought forward by the Residents' Council. The DOC indicated that the concerns brought forward in a specified month, were not responded in writing. The concerns raised another specified month, the DOC was not able to remember the specific issue and why there was no written responses. For the concerns brought forward from third specified month, the DOC indicated that the Administrator was taking care of it.

The Administrator indicated no response was provided in writing following the concerns raised in the specified month meeting, however it had been discuss verbally with the staff members.

The licensee is not responding in writing within 10 days of receiving the Residents' Council advice related concerns or recommendations. [s. 57. (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 the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

During this inspection, the Family Council Minutes for a specified three month period were reviewed by Inspector #547 when the home had a Family Council in place. Concerns were identified and brought forward by the Family Council as follows:

On a specified date, the President of the Family Council provided the Licensee the minutes of another specified Family Council meeting that contained one recommendation to the home's Administrator. The Family Council requested from the Administrator where there would be a private meeting place for visitors and residents at meal times.

The Administrator indicated to Inspector #547 to have responded to the Family Council verbally two months later at a specified Family Council meeting regarding this request. The Administrator indicated no written response was provided to the Family Council as required by this section. [s. 60. (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 the licensee responds in writing within 10 days of receiving Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle is reviewed by the Resident's Council.

During this inspection, Inspector #592 interviewed the President of Resident's Council, who indicated that the home has not reviewed any menu cycle with the Resident's Council.

The Food Services Supervisor(FSS) indicated to Inspector #547 that the home was currently serving residents the winter menu cycle. The FSS indicated the home has two menu cycles, being summer and winter cycles. The FSS indicated the winter menu cycle would have began on a specified date approximately four months earlier however this menu cycle was not reviewed with the resident's council. The FSS further indicated that the summer menu would have began on a specified date that was also not reviewed by resident's council.

As such, the menu cycles served to residents in the home was not reviewed by the Residents' Council as required by this section. [s. 71. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu is reviewed by the Residents' Council, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

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

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to inform the Director immediately, in as much detail as is possible in the circumstances of an unexpected or sudden death, including a death resulting from an accident or suicide.

This inspection is related to Log #007813-17.

A Critical Incident Report (CIR) was submitted on a specified date to the Director related to the unexpected death of resident #030 which had occurred on a specified date four days earlier. The Assistant Director of Care (ADOC) had contacted the after-hours pager on a specified date three days after the incident occurred.

In a review of the CIR done by Inspector #592, it was indicated that resident #030 was admitted to the home on a specified date with a specified diagnosis related to swallowing concern and was served specified food item the day after admission at breakfast time that resulted in choking causing sudden death. The CIR indicated that due to previous diagnosis as specified related to swallowing, it was not decided by the coroner and the family physician that the cause of death of resident #030 was unexpected.

During this inspection, in a discussion with the ADOC who submitted the CIR, the ADOC indicated to Inspector #592, that after a discussion with the coroner's office attendant and the home's attending physician, they did not consider the death as unexpected, therefore the ADOC was unsure if the CIR needed to be submitted immediately to the Director.

As such the licensee failed to inform the Director immediately of the sudden death involving resident #030. [s. 107. (1) 2.]

2. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital.

This inspection is related to Log #020096-17.

On a specified date and time, resident #026 had an un-witnessed fall that resulted with specified injuries. The resident was sent to the hospital on another specified date and time for assessment related to uncontrolled pain to the chest and sternum area. The resident's progress notes documented on this specified date, that the hospital informed the home that the resident was being admitted to the hospital due to a specified significant injury.

Inspector #547 reviewed the resident's plan of care prior to hospitalization and post hospitalization, and noted changes to the resident's plan of care was required. The resident had increased comfort measures required, pain assessments, mobility and transfer changes related to the specified injury. The resident had skin related changes related to the injury sustained from the fall and post hospitalization ulcer changes to the plan of care.

The Director of Care indicated that the home did not submit any Critical Incident Report (CIR) for resident #026's hospitalization and change in condition related to significant injury as required by this section. [s. 107. (3) 4.]

3. The Licensee has failed to ensure that the resident's Substitute Decision-Maker (SDM) designated by the resident was promptly notified of a serious injury related to a fall in accordance with any instructions provided by the person or persons who are to be so notified.

This inspection is related to Log #020096-17.

On a specified date, the Director received a complaint from resident #026's SDM regarding an incident whereby resident #026 fell in the home on a specified date, however the SDM was not notified.

Inspector #547 reviewed resident #026's progress notes for this specified date that identified an unwitnessed fall at a specified time. The progress notes indicated resident #026 sustained specified injuries and that the SDM was supposed to be informed later that morning. The progress notes had no documentation of the SDM being notified about the resident's fall. A progress note on another specified date indicated the resident's SDM was upset about not being informed until a specified amount of hours later about resident #026's fall with injuries. The progress notes further indicated the resident was sent to hospital for further assessment related to this fall and admitted to the hospital that evening with a specified significant injury.

Registered Practical Nurse (RPN) #101 indicated to Inspector #547 to have been the RPN on shift after resident #026's fall. RPN #101 indicated that they had not informed resident #026's SDM regarding the fall that occurred early that day as required due to a misunderstanding in roles and responsibilities with registered nursing staff that day.

As such, RPN #101 did not notify the resident's SDM promptly regarding resident #026's injury and fall as required by this section. [s. 107. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure to inform the Director immediately, in as much detail as is possible in the circumstances of an unexpected or sudden death, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents titles Resident's Abuse, was complied with.

This inspection is related to Log #003530-18

According to O.Reg.79/10, s.2.(1) Sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person by a licensee or staff member";

A review of the licensee's policy titled "Resident's abuse" with an effective date of June 1998 with a review date of July 2016 was completed by Inspector #592.

The policy indicated the following:

Staff reporting-Investigative Procedure of Allegation of abuse and neglect:

1. In any case of abuse or suspected abuse, the employee or any other person witnessing or having knowledge of an incident shall, verbally, report the incident immediately to their immediate supervisor.

The Administrator or Director of Care or designated staff shall ensure that all residents are protected from the risk of any further abuse by taking immediate action.

The home's resident's abuse policy further indicated on page six regarding Procedure for Resident Abuse and Neglect Policy on number six of this procedure to:

Prevent and intervene by identifying actual and potential situations where abuse has or might occur. Withdraw the involved resident from the situation to assure security.

On a specified date, a Critical Incident Report (CIR) was completed by the Licensee regarding an incident of an alleged sexual abuse.

The home's internal investigation documents further indicated that Personal Support Worker (PSW) #120 reported to the licensee on a specified date to Registered Practical Nurse (RPN) #124 of the incident of the witnessed staff to resident sexual abuse that occurred on the evening three days earlier.

In a telephone interview with PSW #120, the PSW described what happened on

this specified date of the incident to Inspector #547 and #592. The PSW indicated that the incident occurred at the beginning of the evening shift and was assigned to work with resident #012. PSW **#**120 indicated entering resident **#**012's room with PSW #122 and observed PSW #122 inappropriately touch resident #012 to a specified body part while saying "What is this?". PSW **#**122 heard resident **#**012 indicating to both PSW's "I don't like that when this person does that". PSW **#**120 indicated to Inspectors #592 and #547 to not have immediately reported to any immediate supervisor until three days later on the evening shift to RPN #124. PSW #120 further indicated having discussed this incident of staff to resident sexual abuse with PSWs #121.

In a telephone interview with PSW #121, the PSW indicated having worked on the evening shift of this specified date of the incident, and PSW #120 described the staff to resident sexual abuse of PSW #122 and resident #012. PSW #121 indicated to Inspectors #592 and #547, to not have reported this incident of sexual abuse to any immediate supervisor as this was hear say, and PSW #121 did not actually witness the abuse and that it was PSW #120's role to report what was witnessed. PSW #121 further indicated that PSW #123 was also made aware of this incident by PSW #120 on the specified evening.

In a telephone interview with PSW #123, the PSW indicated having worked on the specified evening shift, and PSW #120 described the staff to resident sexual abuse of PSW #122 and resident #012. PSW #123 indicated to Inspectors #592 and #547, to not have reported this incident of sexual abuse to any immediate supervisor as PSW #123 did not see this abuse, and is not responsible to report the incident as this was PSW #120's role. PSW #123 further indicated that PSW #128 was also made aware of this incident by PSW #120 on the evening of this specified date.

In a telephone interview with PSW #128, the PSW indicated having worked on the evening shift of this specified date, and PSW #120 described the staff to resident sexual abuse of PSW #122 and resident #012. PSW #128 indicated to Inspectors #592 and #547, to not have reported this incident of alleged sexual abuse to any immediate supervisor as PSW #120 was reporting what was witnessed.

In an interview with PSW #120, the PSW indicated having discussed the staff to resident sexual abuse with PSW #121, #123 and #128, being the PSW team working the evening of this specified date and being aware that PSW #122 was schedule to work with resident #012 and other residents on this specified date and

the next day after this incident occurred.

In an interview with the Assistant Director of Care (ADOC), the ADOC indicated to Inspectors #547 and #592 to have been made aware of the incident of staff to resident sexual abuse of resident #012. The ADOC and DOC became aware by RPN #124 at the beginning of the evening shift on a specified date, three days after the incident occurred.

Specifically, PSWs staff working on the evening of the specified date of the incident, did not comply with the licensee's policy regarding Resident's Abuse dated July 2016, which is part of the licensee's prevention of abuse program. [s. 20. (1)]

2. This inspection is related to log #011942-17

According to O.Reg. 79/10, s.2(1) physical abuse is defined, subject to subsection (2):

a) the use of physical force by anyone other than a resident that causes physical injury or pain,
c) the use of physical force by a resident that causes physical injury to another resident.
Subsection (2) indicated for the purposes of clause a) of the definition of physical abuse in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

On a specified date, the Assistant Director of Care (ADOC) reported a Critical Incident Report (CIR) regarding an incident that caused an injury to resident #032 that occurred on a specified date. The home began an immediate investigation into this incident regarding possible physical abuse towards resident #032 as no recorded falls for this resident, who is dependent for all care and requires mechanical lift for transfers.

The Licensee's Resident's Abuse policy indicated the following:

On page 2 regarding physical abuse, that this is any act of violence or rough treatment, whether or not actual physical injury results. This represents infliction or physical pain, wherein discomfort, pain, injury was a consequence.

On page 7 section 6.(d) the Ministry of Health and Long-Term Care (MOH-LTC)will be notified of any incidents of suspected resident abuse at the earliest possible time via the Critical Incident via electronic system (CIR).

The ADOC indicated to Inspector #547 that no critical incident report was sent to the MOH-LTC via the CIR for this incident.

The ADOC further provided a copy of the home's Critical Incident System Reporting policy with effective date March 2017 that goes with the homes abuse policy for registered nursing staff in the home that indicates the following:

"RN/RPN on duty who is made aware of an incident that must be reported to the Director (MOHLTC) and does not have access to the on-line critical incident reporting system, should report immediately using the on call reporting after hours pager number for the Director (MOHLTC)".

This injury was identified during regular business hours, however was not reported vie the CIR or the on-call after hour pager number for the Director until two days after the incident occurred.

The Resident's Abuse policy indicated the following:

#7. In all cases where sufficient evidence exists to substantiate an allegation of physical abuse, the Administrator, Director of Care, Assistant Director of Care or designate must notify the Police.

The ADOC indicated that no police force was notified of this incident as required by policy.

The Resident's Abuse policy indicated the following:

#9 c) The administration is responsible to take corrective actions when abuse has occurred or where there exist a strong suspicion but no conclusive proof till the investigation is completed. A final report should be submitted to the Ministry of Health and Long-Term Care that outlines the findings of the investigation and the corrective actions when completed within one month of the initial report to the Director.

The CIR reported by the Licensee does not contain any final report that outlines the results of the investigation and corrective actions as required by policy.

As such, the Licensee's policies titles Resident Abuse and Critical Incident System Reporting in place in the home were not complied with when this incident of alleged, suspected physical abuse of resident #032 on a specified date. [s. 20. (1)]

3. The licensee has failed to ensure that the Licensee's Resident Abuse policy and procedure was complied with.

This inspection is related to log #005719-18.

According to O.Reg. 79/10, s.2(1) physical abuse is defined, subject to subsection (2):

a) the use of physical force by anyone other than a resident that causes physical injury or pain,
c) the use of physical force by a resident that causes physical injury to another resident.
Subsection (2) indicated for the purposes of clause a) of the definition of physical abuse in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

On a specified date, the Director of Care (DOC) reported a Critical Incident Report (CIR) regarding an incident that caused an injury to resident #034 that was identified five days earlier.

The Licensee's Resident Abuse policy and procedure indicated the following:

On page 2 regarding physical abuse, that this is any act of violence or rough treatment, whether or not actual physical injury results. This represents infliction or physical pain, wherein discomfort, pain, injury was a consequence.

On page 7:
Section 6.(b) further investigation is required to substantiate abuse incident report is to be completed as per the home policy;

Section 6.(d) that the Ministry of Health and Long-Term Care (MOH-LTC)will be

notified of any incidents of suspected resident abuse at the earliest possible time via the Critical Incident via electronic system (CIR);

Section 7 indicated where sufficient evidence exists to substantiate an allegation of physical abuse, the Administrator, the Director of Care, the Assistant Director of Care or designate must notify the police.

On Page 8:

Section 9(c) The Administration is responsible to take corrective actions when abuse has occurred or where there exist a strong suspicion but no conclusive proof till the investigation is completed and a final report should be submitted to the Director.

The Licensee's Critical Incident System policy and procedure stated the definition of Critical Incident is any incident even, situation or accident that results in potential or actual risk of harm to residents. The action required indicated the RN/RPN on duty who is aware of an incident must report to the Director immediately.

The Licensee did not submit the Critical Incident until five days after the registered nursing staff were made aware of assessed the resident for significant change in condition with injury and pain.

The Licensee did not immediately investigate this incident as required.

The Licensee did not immediately report this incident to any police force.

The Licensee did not immediately report to the resident's SDM the resident's incident of significant change in the resident's health condition causing pain to resident #034. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of physical abuse of resident #012 by anyone that the licensee knows of, or that is reported to the licensee, was immediately investigated.

This inspection is related to Log #003530-18

According to O.Reg.79/10, s.2.(1) Sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person by a licensee or staff member";

On a specified date, a Critical Incident Report (CIR) was completed by the home regarding an incident of an alleged sexual abuse which had occurred on a specified date. It was documented in this report that Personal Support Worker (PSW) #120 observed PSW #122 inappropriately touch resident #012 to a

specified body part while saying "What is this?".

The Licensee's internal investigation documents were reviewed by Inspector #592. The home's documentation indicated that PSW #120 witnessed PSW #122 inappropriately touch resident #012's specified body part and that resident #012 told PSW #120 and #122 "I don't like it when this person does that".

In an interview with the Assistant Director of Care (ADOC) with the presence of Inspector #592 and #547, the ADOC told both Inspectors that the incident of sexual abuse had been reported to them on a specified date by Registered Practical Nurse (RPN) #124 and PSW #120. The ADOC indicated being told verbally by RPN #12 and PSW #120 the details of the alleged sexual incident and that following the discussion, the ADOC requested to have the details of the incident and what was observed documented on paper, which was provided the following day by the PSW #120.

The ADOC indicated that a follow-up with resident #012 was done following the report of the incident on this specified date such as a visual check to ensure that the resident was safe, however no immediate investigation was done until the following day, when the documented incident from PSW #120 was received. The ADOC further indicated that the investigation to this incident was not documented. The DOC did ask some of the other alert female residents in the home if any inappropriate touching from staff had occurred, and no resident had any other incidents to report. [s. 23. (1) (a)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident of physical abuse of resident #034 that the Licensee knows of, or that is reported is immediately investigated.

This inspection is related to log #005719-18.

According to O.Reg. 79/10, s.2(1) physical abuse is defined as:
a) the use of physical force by anyone other than a resident that causes physical injury or pain,
c) the use of physical force by a resident that causes physical injury to another resident.

On a specified date, the Licensee reported a Critical Incident Report (CIR) regarding resident #034 sustained a significant injury from an incident of unknown

cause. The resident's injury was significant that the residents physician requested the resident be sent to hospital for further examination. The resident's health care records did not record any recent falls that may have caused this injury. The CIR further indicated that the resident's injury was first observed on the night shift by the night charge Registered Nurse (RN) five days earlier.

Resident #034 was admitted to the home on a specified date with several medical diagnoses and required total assistance for all personal care including washing, dressing, toileting and transfers. Resident #034 required a specified transfer during the period of time the injury occurred.

Inspector #547 reviewed the resident's progress notes that documented assessment on a specified date during day shift and evening shifts after the injury was first identified. Resident #034 required pain medication and medication for agitation daily until the resident was sent to the hospital four days later for further assessment of the resident's injury.

The Director of Care (DOC) indicated during interview with Inspector #547 that the resident's injury remained from unknown cause. The Assistant Director of Care (ADOC) indicated that the resident's injury and pain were of unknown cause. ADOC indicated that it was likely related to transfer, but no indication of incidents during transfers identified to cause this injury.

Investigation was documented to have begun on a specified date for this injury that was identified four days earlier. As such, this significant injury to resident #034 was not immediately investigated. [s. 23. (1) (a)]

3. The licensee has failed to ensure that the results of the alleged or suspected abuse or neglect investigation were reported to the Director.

This inspection is related to Log #011942-17

The Licensee submitted a CIR on a specified date, regarding and incident that caused an injury to resident #032 two days earlier that resulted in harm. Investigation began immediately when this injury was reported to the Licensee, and results of the investigation were documented in resident #032's progress notes from the Administrator on a specified date, several days later. The CIR to the Director was not provided results of the alleged or suspected abuse investigation as required by this section. [s. 23. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

This inspection is related to Log #003530-18

According to O.Reg.79/10, s.2.(1) Sexual abuse is defined as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed

towards a resident by a person by a licensee or staff member";

On a specified date, a Critical Incident Report (CIR) was completed by the home regarding an incident of an alleged sexual abuse which had occurred four days earlier. It was documented in this report that Personal Support Worker (PSW) #120 observed PSW #122 inappropriately touch resident #012 to a specified body part while saying "What is this?".

The home's internal investigation documents were reviewed by Inspector #592. The home's documentation indicated that PSW #120 witnessed PSW #122 inappropriately touch resident #012's specified body part and that resident #012 told PSW #120 and #122 "I don't like it when this person does that".

In an interview with the Assistant Director of Care (ADOC) with the presence of Inspector #592 and #547, the ADOC told both Inspectors that the incident of abuse had been reported on a specified date, three days later by RPN #124. The ADOC indicated being told verbally by Registered Practical Nurse (RPN) #124 and PSW #120 the details of the sexual incident and that following the discussion, the ADOC requested to have the details of the incident and what was observed on paper, which was provided the following day by the PSW #120. The ADOC indicated that the Director was not informed until later on the following day, once the letter was received by the PSW #120.

Therefore, the information pertaining to the incident of sexual abuse was not reported to the Director immediately as required by this section. [s. 24. (1)]

2. This inspection is related to Log #011942-17

On a specified date, the Assistant Director of Care (ADOC) submitted a Critical Incident Report (CIR) to the Director regarding an incident that caused an injury to resident #032 on a specified date two days earlier.

The Licensee had reasonable grounds to suspect that physical abuse of resident #032 by anyone that resulted in harm. This incident was not reported immediately to the Director as required until two days after resident #032 presented with significant injury and pain. [s. 24. (1)]

3. This inspection is related to log #005719-18.

The licensee has failed to ensure that the Licensee who had reasonable grounds to suspect that improper or incompetent treatment of care of resident #034 that resulted in harm, immediately report this suspicion and the information upon which it was based to the Director.

On a specified date, the night Charge RN in the home documented an assessment of resident #034 to have sustained a significant injury to a specified body part for no known origin that required monitoring by registered nursing staff. The day and evening shift registered nursing staff in the home monitored and documented assessments of the resident's injury. The Licensee submitted a critical incident to the Director five days after the significant injury was identified by the Licensee. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012's Substitute Decision Makers (SDM) was notified immediately upon the licensee becoming aware of the witnessed incident of sexual abuse of resident #012.

This inspection is related to Log #003530-18.

On a specified date, a Critical Incident Report (CIR) was completed by the Licensee regarding an incident of an alleged staff to resident sexual abuse. It was documented that on an earlier specified date, Personal Support Worker (PSW) #120 observed PSW #122 inappropriately touch resident #012 to a specified body part while saying "What is this?".

The Licensee's internal investigation documents were reviewed by Inspector #592. The home's documentation indicated that PSW #120 witnessed PSW #122 inappropriately touch resident #012's specified body part and that resident #012 told PSW #120 and #122 "I don't like it when this person does that".

The Assistant Director of Care (ADOC) and the Director of Care (DOC) were informed of the incident, three days later by Registered Practical Nurse (RPN)#124 and PSW #120.

The ADOC indicated to Inspector #592 that following the report of the incident of sexual abuse on this specified date three days after the incident occurred, the investigation was started on the next day around 1030 hours following a discussion with the DOC/ADOC and Administrator. The ADOC indicated that the SDM was notified by the Administrator following the home's discussion, therefore the resident's SDM was informed by the Administrator one day after the Licensee was made aware of the incident of staff to resident sexual abuse.

As such, resident #012's SDM's was not notified immediately upon the licensee becoming aware of the witnessed incident of abuse or neglect of the resident. [s. 97. (1) (a)]

2. This inspection is related to log #005719-18.

The licensee has failed to ensure that resident #034's Substitute Decision Maker (SDM) was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury and pain to the resident, and caused distress to the resident that could

potentially be detrimental to the resident' s health or well-being.

Inspector #547 reviewed the resident's progress notes that documented the resident's SDM was notified on a specified date four days after the significant injury was first identified that required further assessment in hospital.

As such, the resident's SDM was not immediately notified of this physical injury and pain that caused resident #034 distress that could have been detrimental to the resident's health and well-being. [s. 97. (1) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of alleged sexual abuse of resident # 012.

This inspection is related to Log #003530-18

On a specified date, a Critical Incident Report (CIR) was completed by the Licensee regarding an incident of an alleged sexual abuse which had occurred on a specified date four days earlier. It was documented in this report that Personal Support Worker (PSW) #120 observed PSW #122 inappropriately touch resident #012 specified body part while saying “What is this?”.

The Licensee’s internal investigation documents were reviewed by Inspector #592. The home’s documentation revealed that PSW #120 witnessed PSW #122

inappropriately touch resident #012's specified body part and that resident #012 told PSW #120 and #122 "I don't like it when this person does that".

The Assistant Director of Care (ADOC) and the Director of Care (DOC) were informed of the incident by Registered Practical Nurse (RPN)#124 and PSW #120 on a specified date, three days after the incident occurred.

The ADOC indicated to Inspector #592 that following the report of the incident of sexual abuse on this specified date, the investigation was started on the next day following a discussion with the DOC/ADOC and Administrator. The ADOC indicated that the police was then notified later on this date.

As such, the police force was not immediately notified of the witnessed sexual abuse. [s. 98.]

2. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged or suspected incident of abuse or neglect of resident #032.

This inspection is related to Log #011942-17

The Licensee submitted a CIR on a specified date regarding and incident that caused an injury to resident #032 on another specified date that resulted in harm. Investigation began immediately when this injury was reported to the Licensee however no police force was ever notified for this incident as required by this section. [s. 98.]

3. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of resident #034.

This inspection is related to log #005719-18.

The Licensee submitted a CIR on a specified date regarding and incident that caused an injury to resident #034 first identified four days earlier that resulted in harm. The resident's health care records were reviewed by Inspector #547 and no police force were documented to have been notified regarding this significant injury and pain to resident #034.

The ADOC indicated that no police force was ever contacted regarding an incident that caused a significant injury to resident #034. [s. 98.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Over the course of the inspection, the process for medication incident reporting was reviewed by Inspector #592 with the Director of Care (DOC).

The Inspector #592 reviewed medication incidents for a specified three month period.

During the review, it was noted that there was two instances when two residents' medications were not administered to those residents in accordance with the directions for use specified by the prescriber.

The first incident is involving resident #023:

On a specified date, resident #023 was administered a specified medication at a specified time and then again 75 minutes later, when the physician orders and directions were to administer this specified medication every four hours as needed.

Upon a review of the analysis and follow-up done by the DOC, it was indicated that the medication was administered as the registered staff had not signed the Medication Administration Records (MAR) indicating that the medication had been administered earlier, therefore a second administration was done 75 minutes later.

The second incident is involving resident #022:

On a specified date, resident #022 was administered a specified medication at 2120 hours, when the physician orders and directions were to administer an extra dose of this specified medication at 1300 hours if needed.

Upon a review of the analysis and follow-up done by the DOC, it was indicated that the specified medication was administered at the wrong time. The documentation further indicated that the registered nursing staff should correctly review the physician orders prior to the administration of medications.

Therefore resident #022 and #023 were not administered their drugs in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

a) Documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
b) Reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During this inspection, Registered Nurse (RN) #102 indicated to inspector #592 that when a medication incident occurs in the home, the registered nursing staff have to complete a medication incident report form. RN #102 further indicated that they have to then report this incident to the resident's SDM, the pharmacy, the

resident's physician and the Director of Care (DOC). Once this document is completed, the DOC is then provided with the incident report form and reviews the information and then manages with the nursing staff member involved. The RN also indicated that a review of the medication incident was done at their registered nursing staff meeting.

Inspector #592 reviewed the Licensee's medication incident reports for two incidents that occurred in a specified three month period completed by registered nursing staff in the home. This report indicated that the incidents shall be reported to the physician, the relative/SDM and pharmacy service provider and to indicate the date and time it is reported. This report also contained the documentation required under what immediate care or actions have been taken. Inspector #592 also noted that the medication incident reports were signed and dated by the DOC.

It was noted that the physician, the SDM and the pharmacy service provider were not made aware of these medication incidents involving residents in the home and that no documentation was completed under immediate care or actions that have been taken following these two medication incidents.

The DOC indicated that upon review of the two medication incidents for residents reviewed in the home, that no physician, SDM, pharmacy service provider were documented as being informed. The DOC further indicated that immediate care or actions that have been taken following these two medication incidents were not documented. The DOC indicated that a review will be done of the process for completing the medication incident reports with registered nursing staff as identified in the home's process. [s. 135. (1)]

2. The licensee has failed to ensure that,

(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

Over the course of the inspection, the process for medication incident reporting was reviewed by Inspector #592 with the Director of Care (DOC).

The DOC indicated that each medication incident is reviewed and that the DOC was responsible to respond to those medication incidents involving residents.

The Inspector #592 reviewed medication incidents for a specified three month period.

The medication incident reports identified two medication incidents that occurred in this period of time, which was completed by the registered nursing staff in the home and signed by the DOC. The Inspector also noted that an analysis and a follow-up was done for each medication incidents by the DOC.

During an interview with Inspector #592, the DOC indicated that the medication incidents are reviewed and evaluated for each resident, however no quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home. The DOC further indicated that therefore no changes and improvements were identified or implemented but that it was part of the home's plan in the upcoming future. [s. 135. (3)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 1 day of August 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by LYNE DUCHESNE (117) - (A2)

Inspection No. / No de l'inspection : 2018_621547_0019 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 007094-18 (A2)

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

Report Date(s) / Date(s) du Rapport : Aug 01, 2018;(A2)

Licensee / Titulaire de permis : Genesis Gardens Inc.
1004 Buckskin Way, Orleans, ON, K1C-2Y6

LTC Home / Foyer de SLD : Foyer St-Viateur Nursing Home
1003 Limoges Road South, Limoges, ON, K0A-2M0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Benoit Marleau

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Genesis Gardens Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure to protect resident #012, resident #032 and resident #034 and any other resident from abuse.

1. All staff shall complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners on all forms of resident abuse. The education should include but not limited to:

a. A review of the Licensee's Resident Abuse policy as outlined in the LTCHA, 2007 s. 20 indicates that the Licensee shall ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with,

b. A review of the Licensee's duty to investigate every alleged, suspected or witnessed incident of abuse or treatment of a resident causing significant injury immediately as outlined in LTCHA, 2007 s. 23,

c. The mandatory reporting obligations as outlined in the LTCHA, 2007 s. 24 indicates that a person who has reasonable ground to suspect that abuse of a resident by anyone or neglect by staff member has occurred or may occur shall immediately report the suspicion and the information upon which it is

based to the Director,to the resident's Substitute Decision Maker and to the appropriate police force,

d. Attendance records education shall be documented for all education.

2. Develop a monitoring process to ensure that:

a) Every incident of alleged, suspected or witnessed incident of abuse is immediately investigated,

b) A person who has reasonable grounds to suspect that abuse has occurred or may have occurred shall immediately report the suspicion to the Director,

c) The residents SDM is immediately notified of every incident of alleged, suspected or witnessed incident of abuse,

d) The appropriate police force is immediately notified of all alleged, suspected, or witnessed incidents of sexual abuse that the licensee suspects may constitute a criminal offense.

3. A record of this monitoring process must be documented and kept in the home.

Grounds / Motifs :

1. The home has a level 4 history as they had previous order for non-compliance with this section with the Long-Term Care Homes Act, 2007, that included:

Compliance Order (CO) s.19 duty to protect issued January 10, 2017 (2017_620126_0001) (547)

2. The home has a level 4 history as they had previous order for non-compliance with this section with the Long-Term Care Homes Act, 2007, that included:

Compliance Order (CO) s.19 duty to protect issued January 10, 2017 (2017_620126_0001) (547)

3. The home has a level 4 history as they had previous order for non-compliance with this section with the Long-Term Care Homes Act, 2007, that included:

Compliance Order (CO) s.19 duty to protect issued January 10, 2017 (2017_620126_0001) (592)

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

Sep 14, 2018(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must:

1. Ensure resident #031 and any other resident including residents at high risk for choking are provided with their prescribed diets and specific nutritional interventions including but not limited to interventions related to dysphagia and the prevention of choking as specified in the plan of care.

2. Ensure that all dietary, activity and nursing staff of the long-term care home are provided training on the provision of safe foods and fluids to residents specifically related to texture modified foods and fluids, dysphagia and other factors related to choking risk. Attendance records are to be maintained for this training.

3. Establish a monitoring process to ensure that the prescribed diet and other nutritional interventions provided as specified in the plan of care and implement corrective actions if the interventions are not effective. A record of this monitoring process must be documented and kept in the home.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care for resident #030 was provided to the resident as specified in the plan.

This inspection is related to Log #007813-17.

A Critical Incident Report (CIR) was submitted by the Licensee on a specified date, related to the unexpected and sudden death of resident #030 four days earlier while eating a specified item which caused the resident to choke.

Inspector #592 reviewed resident #030's health care records which indicated the resident was admitted the day before this incident with several medical diagnoses including a specified diagnosis related to difficulty swallowing. The hospital discharge information for swallowing completed the day prior to admission to the Long-Term Care home provided specific diet recommendations and interventions.

Inspector #592 reviewed the Licensee's initial Admission Nursing Assessment and 24 Hour Care Plan that indicated resident #030 required one person assistance for eating with close supervision, related to coughing and risk of aspiration.

Inspector #592 reviewed the home's Unit Daily Record for the specified admission date and the following day of the incident. The Unit Daily Record dated for the evening shift of the date of admission, indicated that resident #030 was newly admitted and was to be seated at a specific table with close supervision required by nursing staff. The Unit Daily Record indicated that nursing staff were to ensure that the resident ate slowly and swallowed food before taking another spoonful.

During this inspection, Inspector #592 interviewed Personal Support Workers (PSWs) #115 and #116, who indicated that when a resident is admitted to the home, all the information regarding nutritional needs and level of assistance required on a specific form which is made available for all nursing staff members. Both PSWs also indicated that all information is to be communicated on the 24 hour nursing report (Unit Daily Record) at each change of shift for several days until the staff know the resident. The PSW's further indicated if they were unsure about care needs, they were instructed to refer to the registered nursing staff for guidance. PSW #115 who was present during the incident involving resident #030 indicated to the Inspector not being assigned to assist the resident at breakfast time when the incident occurred, however indicated that resident #030 was heard coughing and that the PSW who was present at the table with the resident had called for help. PSW #115 further indicated that resident #030 was identified as being at high risk for choking as the resident was eating very fast and that the staff needed to slow the resident down after each bite. PSW #115 indicated that the resident was sitting at a table with the

presence of a PSW at all times, however did not recall which PSW was assigned to the resident on that day. PSW #115 further indicated that all PSWs were made aware by the RN at the 0600 hours morning report on this specified date after the resident's admission regarding resident #030 specific diet recommendations and interventions.

PSW #117 indicated to Inspector #592 to be assigned resident #030's table at breakfast time when the incident occurred on a specified date. PSW #117 indicated that resident #030 was eating with no assistance and was sitting at this table in order to be provided with some supervision while the PSW was feeding other residents at the same table. PSW #117 indicated that resident #030 was sitting in a wheelchair on the opposite side of the table. PSW #117 indicated that another PSW had provided some instructions about resident #030 potential to choke and that PSWs were to monitor the resident. PSW #117 indicated that resident #030 had been served a specified food item by the kitchen staff and was observed to be eating very fast. PSW #117 indicated that approximately two minutes later, resident #030 started coughing and the nurse was immediately called. PSW #117 indicated not being aware of any other interventions at that time specifically for resident #030. Inspector #592 inquired about how the PSWs are made aware of the specific nutritional needs for newly admitted residents. PSW #117 further indicated that usually, the PSWs will refer to the kitchen staff before they serve the resident for any specific diet or recommendations. PSW #117 indicated on this specified date, the residents were served these specific food items in the morning by the kitchen staff, and did not need to verify with the kitchen staff for resident #030 diet.

The Director of Care (DOC) and the Assistant Director of Care (ADOC) indicated to Inspector #592 that the information for nutritional needs for resident #030 was communicated at the morning report. The DOC and the ADOC indicated that PSW #117 did not provide the care set out in the plan of care to resident #030 related to nutritional needs as specified in the resident's plan of care.

2. Resident # 031 was identified by the DOC and the ADOC to be at high risk for choking and to have specific nutritional interventions in place to prevent choking.

A review of resident #031's health care records was completed by Inspector #592 which indicated that resident #031 was admitted on a specified date,with several medical diagnoses. According to the most recent assessment provided by the

Speech Language Therapist completed on a specified date, resident #031 required total assistance of staff with feeding as the resident had the tendency to hold food in the mouth when eating. Resident #031 was assessed as being able to swallow adequately when given verbal cues to swallow by staff. Several recommendations were documented in the resident's written plan of care.

On a specified date during this inspection, Inspector #592 observed a food service worker distribute beverages in the dining room for the breakfast meal service and then poured honey texture fluids in three regular plastic glasses. Inspector #592 observed these three regular plastic glasses on a resident's table, one with water, another with milk and a third one with orange juice. A plastic container labelled thickener was also observed beside these three plastic glasses. PSW #106 indicated to Inspector #592 that the thickener powder was required for resident #031. This thickener powder is to be added by the nursing staff to make the honey textured fluid to a pudding consistency for the resident so that the fluid should not drip from the spoon. PSW #106 further indicated that resident #031 forgets to swallow and the staff have to cue the resident to swallow after each bite.

Inspector #592 observed Registered Nurse (RN) #102 sit beside resident #031 for this breakfast meal service, while the food services staff served the resident a specified food item. Inspector #592 observed RN #102 taking the glass of milk and stirring it with a spoon without adding any thickener powder. RN #102 turned towards the resident to provide the glass of milk when RN #102 was stopped by PSW #106 who indicated that the RN needed to add some thickener powder to the glass in order to thicken the fluid to a pudding consistency. RN #102 proceeded to add some thickener powder to the glass of milk and stirring the glass of milk with a spoon and then proceeded to give resident #031 a teaspoon of milk. Inspector #592 observed that the milk was not a pudding consistency, as the milk was observed dropping from the spoon. Inspector #592 approached resident #031's table and RN #102 had already provided resident #031with the spoonful of milk and milk was observed leaking out from the resident's mouth. Inspector #592 asked RN #102 what texture and consistency was being provided to resident #031. RN #102 indicated that the texture prepared for resident #031 was appropriate as there was no jelly thickener available that morning, therefore was using the powder thickener which was not the same and was not the same consistency. Inspector #592 asked if RN #102 was aware of the detailed description for the requirement for pudding consistency for fluids that should not drop from the spoon. RN #102 showed Inspector #592 the texture which was dropping from the spoon and said that it was the proper texture.

RN #102 then consulted with PSW #112 who was the regular PSW assigned to resident #031 who did not yet join the table and was informed by PSW #112 that the consistency was not appropriate for resident #031 as it was too liquid and PSW #112 was observed pushing away the two other glasses which contained water and orange juice. PSW #112 was observed adding thickener powder to the glass of milk until the milk texture was no longer dripping from the spoon. RN #102 indicated to Inspector #592 of being aware of resident #031's fluid consistency as the RN had been involved with the resident and the Speech Language Therapist, however the RN indicated that due to not having the jelly thickener, it was hard to have the right texture for the resident that morning.

On a specified date, the ADOC indicated to Inspector #592 that the instructions were very descriptive and clear for the specific nutritional interventions to be provided to resident #031. The ADOC indicated that time was taken during the consultation with the Speech Language Therapist to ensure that all the specific requirements such as the description of the pudding texture was clear for all the staff members who were taking care of resident #031. The ADOC further indicated that resident #031 nutritional needs were not provided as specified in the plan of care.

The severity of these issues was a level 3 as there was Actual harm to resident #030 and risk of harm to resident #031. The scope was a level 2 as it related to two of three residents reviewed. The home had a level 3 history as they had one or more related non-compliance with this section of the LTCHA, 2007 that included:

Written notification made under s. 6(7) of the Regulations, October 26, 2015.
Written notification made under s. 6(7) of the Regulations, August 15, 2017. (592)

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

Jul 13, 2018(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 1 day of August 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LYNE DUCHESNE - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Ottawa