Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2020	2019_715672_0018	017182-19, 017680-19, 017954-19, 020082-19, 020466-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Northumberland
983 Burnham Street COBOURG ON K9A 5J6

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

Golden Plough Lodge
983 Burnham Street COBOURG ON K9A 5J6

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 1, 6, 7, 8, 12 and 13, 2019

The following intakes were inspected during this Critical Incident System inspection:

Intakes related to two falls.

An intake related to a Critical Incident Report regarding an allegation of resident to resident abuse.

Intakes related to two Critical Incident Report regarding allegations of staff to resident abuse or neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Directors of Care (ADOC), Administrative Assistant (AA), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Behavioural Supports Ontario (BSO), Occupational Therapist (OT), RAI-MDS Coordinator, family members, residents and visitors to the home.

During the course of the inspection, the inspector(s) reviewed health care records, observed residents, reviewed the home's investigation records, reviewed employee and training records, schedules and the following policies: Prevention of Abuse and Neglect, Falls Prevention and Management, Restraints, Personal Assistance Services Devices and Pain Management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

9 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 resident #005's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated the fall resulted in the resident being transferred to hospital and diagnosed with injuries which required specified treatments. The CIR further indicated that at the time of the fall, resident #005 was receiving personal care while in the bed from PSW #125, with the bed elevated. PSW #125 walked away from the bed to secure personal care supplies and resident #005 fell. PSW #125 was providing personal care to the resident independently.

Review of resident #005's RAI-MDS Assessment in place at the time of the incident indicated resident #005 had an identified exhibited responsive behaviour. The assessment further stated that resident #005 required extensive assistance from two staff members to physically assist with bed mobility and required total assistance from two staff members to physically assist with personal hygiene.

Review of resident #005's written plan of care in place at the time of the incident stated the resident had multiple risk factors related to falling and had sustained previous falls in the past. Resident #005 was considered to be at high risk for falling and had several interventions in place to assist in preventing falls from occurring. The interventions indicated resident #005's bed was to be in the lowest position for safety when staff were not providing care. Resident #005 required assistance from two staff members for the provision of care including bed mobility.

During an interview, PSW #124 indicated resident #005 required two staff members to provide personal hygiene and that the bed should always be placed in the lowest position when a staff member was not at the bedside to prevent the resident from falling.

During an interview, RPN #122 indicated resident #005's bed should always be in the lowest position when a staff member was not at the bedside to prevent the resident from falling. The expectation in the home was for the resident's plan of care to be followed at all times regarding the amount of staff members required to assist in providing activities of daily living to the resident.

PSW #125 was not available for interview during this inspection.

During an interview, ADOC #100 indicated that an internal investigation into resident #005's fall had found that at the time of the fall, PSW #125 raised resident #005's bed while providing personal care. ADOC #100 further indicated that PSW #125 had been providing personal hygiene care to resident #005 independently and stepped away from resident #005's bed to obtain personal care supplies without lowering the bed. ADOC #100 indicated the expectation in the home was for every residents' plan of care to be provided to the resident as specified in the plan. ADOC #100 further indicated resident #005 should have had two staff members present to provide personal care as indicated in resident #005's plan of care and PSW #125 should have lowered the bed prior to walking away from the bedside.

The licensee failed to ensure that resident #005's plan of care was provided to the resident as specified in the plan when the required number of staff members indicated in the resident's plan of care to provide assistance with personal hygiene had not been implemented and the bed was not lowered when the staff member walked away from the resident's bedside to secure personal care supplies. [s. 6. (7)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that an internal policy was complied with, specific to head injury routines.

According to LTCHA, 2007. O. Reg. 79/10, r. 49 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Inspector #672 reviewed the internal policy entitled “Head Injury Routines”, which indicated that upon notification of a resident suspected of suffering a head injury, the registered staff were expected to conduct a head injury assessment on the resident. The assessments were expected to be performed and recorded every 15 minutes for the first hour post injury. After the first hour, the resident assessment was to be performed and recorded every one hour for the next three hours, then every four hours for the next 20 hours.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated the fall resulted in the resident being transferred to the hospital and diagnosed with injuries which required intervention. The CIR further indicated that at the time of the fall, resident #005 was receiving personal care while in the bed from PSW #125, with the bed elevated. PSW #125 walked away from the bed to secure personal care supplies and resident #005 fell.

Review of resident #005’s written plan of care in place at the time of the incident stated the resident had multiple risk factors related to falling and had sustained previous falls in

the past. Resident #005 was considered to be at high risk for falling and had several interventions in place to assist in preventing falls from occurring. The interventions indicated resident #005's bed was always supposed to be in the lowest position for safety when staff were not providing care and resident #005 required assistance from two staff members for the provision of care.

While reviewing resident #005's health care record and documentation related to the fall, Inspector #672 observed resident #005 was placed on head injury routine (HIR) as a result of the fall. Inspector #672 attempted to review the HIR documentation completed following the fall and observed the assessments had not been completed. The documentation on the form indicated the assessment had not been completed due to resident #005 being at the hospital, despite resident #005 returning from the hospital on the same date. While searching for the HIR documentation related to the fall, Inspector reviewed previous post fall assessments completed for resident #005 and observed a HIR assessment completed after a previous fall. Inspector #672 observed that the document had not been completed according to the internal policy, as the following documentation was missing:

- On a specified date, at three specified times, the document had been left blank, with no assessment of the resident's vital signs, bilateral pupil reactions, extremities or level of consciousness.

- On a specified date, at a specified time, the document had been left blank, with no assessment of the resident's vital signs, bilateral pupil reactions, extremities or level of consciousness. There was also no entry for a specified time, as per the directions for the assessment to be completed every four hours for 20 hours.

Inspector #672 also observed that the "Safety Huddle for Post Falls Follow-Up" which was printed on the back side of the Head Injury Routine document and was designed to assess the reason for the fall; what the staff members, the resident and the family members believed to be the problems leading up to the fall and any recommendations to minimize safety issues which could lead to further falls had been left completely blank on both documents following each of the falls sustained.

During an interview, RPN #122 indicated the head injury routine documentation had not been completed for resident #005 following the fall, as the resident had been transferred to the hospital quickly after the fall occurred, and staff completed a vital sign check on the resident once per shift for three days upon resident #005's return from the hospital. RPN

#122 further indicated the expectation throughout the home was for the head injury routine assessments to be completed and documented in full as directed on the assessment form, along with completing the "Safety Huddle for Post Falls Follow-Up" every time a resident was placed on head injury routine, which was printed on the backside of the head injury routine monitoring form. RPN #122 reviewed resident #005's head injury routine assessment from a specified date, and indicated it had not been completed according to the head injury routine internal policy.

During an interview, ADOC #102 indicated the expectation in the home was for every staff member to comply with each internal policy and procedure, which included the head injury routine assessment and documentation. ADOC #102 further indicated the "Safety Huddle for Post Falls Follow-Up" was internally considered to be part of the head injury routine assessment and post fall follow up, and staff were always expected to complete the document every time a resident was placed on head injury routine. ADOC #102 reviewed resident #005's head injury routine assessments following both falls sustained and indicated they had not been completed according to the head injury routine internal policy.

The licensee failed to ensure the internal policy entitled "Head Injury Routines" was complied with when the head injury routine assessments and "Safety Huddle for Post Falls Follow-Up" had not been completed in full following two falls sustained by resident #005. [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 where the Act or the 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was protected from an incident of abuse by members of the direct care nursing staff.

Inspector #672 reviewed the licensee's internal abuse policy, which outlined the definitions of each type of resident abuse and directions for staff to follow in the event of any suspected or witnessed incidents of resident abuse or neglect.

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse between PSW #104 and resident #003. The CIR indicated that on an identified date, resident #003 was ambulating in a corridor, when PSW #104 attempted to walk by with a co-resident. Resident #003 moved into PSW #104 and the co-resident's personal space and PSW #104 requested the resident move back. Resident #003 became agitated therefore PSW #104 physically restrained the resident, while emergency services were contacted. Resident #003 was transferred to the hospital for further assessment.

Inspector #672 reviewed the internal investigation notes and the critical incident report related to the alleged incident of staff to resident abuse between PSW #104 and resident #003. The internal investigation notes indicated the allegation was founded and resident #003 had been abused by PSW #104.

Review of resident #003's RAI-MDS assessment current at the time of the incident indicated resident #003 was noted to exhibit specified responsive behaviours.

Review of resident #003's progress notes from an identified period of time indicated resident #003 exhibited specified responsive behaviours and had several incidents when the resident exhibited feelings of frustration with co-residents, but there were no documented incidents of resident to resident aggression during this time period.

PSW #104 and RN #103 were not available for interviews during this inspection.

During separate interviews, ADOCs #100 and #102 indicated the home utilized the person-centred care philosophy, which directed each resident was an individual and had the right to refuse care at any time. When a resident refused care, staff were expected to leave the resident and reapproach at a different time, to try again. If a resident exhibited responsive behaviours, the expectation in the home was for staff to remove themselves and/or other residents from the immediate area to ensure everyone's safety, but restraining a resident was not an accepted practice in the home. ADOC #100 indicated all staff in the home received education and training related to resident abuse and working with residents with responsive behaviours, which was mandatory for staff to complete on an annual basis. ADOCs #100 and #102 indicated the allegation of staff to resident abuse had been founded as PSW #104's actions were inappropriate as they did not follow the resident's plan of care and violated the internal policies related to restraints, responsive behaviours and resident abuse.

The licensee failed to ensure that resident #003 was protected from abuse as follows:

- When resident #003's SDM was not immediately notified of the incident of staff to resident abuse until a specified number of days after the incident had occurred and the resident had been admitted to the hospital, as indicated under LTCHA, 2007, r. 97. (1) (a) in WN #005.

- When resident #003's SDM was not notified of the outcome of the internal investigation into the incident of staff to resident abuse, as indicated under LTCHA, 2007, r. 97. (2) in WN #005.

- When the results of the internal investigation into the incident was not reported to the Director, as indicated under LTCHA, 2007, s.23(2) in WN #007. [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that resident #005's specified PASDs were included in the resident's plan of care.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated the fall resulted in the resident being transferred to the hospital and diagnosed with several injuries which required intervention.

During resident observations on two specified dates, Inspector #672 observed that resident #005 had a specified assistive device in place. Resident #005 was assisted with personal care while in the bed by a specified number of staff members and was directed to utilize the specified assistive device during the provision of personal care. Following personal care, resident #005 was assisted to a specified mobility aid, where they were immediately assisted into an identified position. During further resident observations, resident #005 appeared to be in an identified position while in the specified mobility aid at all times, with the exception of during meals.

During separate interviews, PSWs #123 and #124 and RPN #122 indicated that resident #005 had a specified assistive device in place which had been present since resident #005's admission to the home. PSWs #123 and #124 and RPN #122 further indicated that resident #005 utilized the specified assistive device as a PASD during the provision of personal care, for specified reasons. RPN #122 indicated resident #005's specified mobility aid was also utilized as a PASD, as resident #005 spent their time in an identified position while utilizing the specified mobility aid for specified reasons at all times with the exception of meals. PSWs #123 and #124 and RPN #122 indicated that the identified position had the effect of limiting resident #005's freedom of movement for specified reasons.

During record review, Inspector #672 observed resident #005's records in place prior to and following the fall. Neither of the written plans of care or POC documentation had a focus, goals or interventions specific to resident #005 utilizing either of the identified PASDs.

During separate interviews, RPNs #119, #121 and #122 and RN #108 indicated there had been no education or guidance in the home regarding the utilization of PASDs. RPNs #119, #121 and #122 and RN #108 further indicated no residents had a focus, goals or interventions listed in their plan of care related to the usage of a PASD, as staff were unaware of what constituted a PASD, what was required prior to the usage of a PASD or what assessments were required related to the utilization of a PASD. RPNs #119, #121 and #122 and RN #108 indicated that the specified assistive devices utilized by resident #005 had not been considered to be PASDs in the home previously, therefore staff had not considered residents who utilized the same specified assistive devices to

require a plan of care related to the usage of PASDs.

During separate interviews, ADOCs #100 and #102 indicated the expectation in the home was for PASDs utilized by a resident to be included in the resident's plan of care. ADOCs #100 and #102 further indicated there had been confusion in the home regarding which devices were considered to be PASDs, and currently the specified assistive devices utilized by resident #005 were not included in residents' plans of care unless they were considered to be restraints to the resident.

The licensee failed to ensure that resident #005's plan of care included the PASDs utilized by the resident. [s. 33. (3)]

2. The licensee failed to ensure that resident #004's PASDs were included in the resident's plan of care.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004. The CIR indicated that resident #004 had a specified assistive device at the head of the bed, which the resident had requested be disengaged. Before the specified assistive device could be disengaged, the resident was observed to have climbed up and over it, falling to the floor. Resident #004 was then transferred to hospital and admitted with an identified diagnosis which required intervention.

During separate interviews, PSW #113, RPNs #119 and #121 and PT #120 indicated that following resident #004's return to the home from the hospital, resident #004 utilized a specified mobility aid as a PASD, as the mobility aid was kept in an identified position for specified reasons. PSW #113 and RPNs #119 and #121 further indicated that resident #004 had another specified assistive device in place since the resident was admitted to the home, which resident #004 utilized as a PASD for specified purposes.

During record review, Inspector #672 observed resident #004's records in place prior to and following the fall. Neither of the written plans of care or POC documentation appeared to have a focus, goals or interventions specific to resident #004 utilizing either of the PASDs.

The licensee failed to ensure that resident #004's plan of care included the PASDs utilized by the resident. [s. 33. (3)]

3.The licensee has failed to ensure that resident #004's PASDs were approved by any of

the professionals listed in the legislation.

During review of resident #004's health care record, Inspector #672 did not observe any approval related to resident #004's usage of either of the specified devices which were both utilized as a PASD for identified purposes.

During separate interviews, Inspector #672 reviewed resident #004's health care record with RPNs #119 and #121. Both RPNs indicated they could not locate an approval from one of the professionals listed within the Regulation specific to resident #004's usage of the specified mobility aid as a PASD.

The licensee failed to ensure that resident #004's PASDs were approved by any of the professionals listed in the legislation prior to using the devices. [s. 33. (4) 3.]

4. The licensee failed to ensure that resident #005's identified PASDs were approved by any of the professionals listed in the legislation.

During review of resident #005's health care record, Inspector #672 did not observe any approvals related to resident #005's usage of the specified mobility aid as a PASD. A physician's approval and informed consent related to the usage of the specified assistive device as a PASD had been obtained, as resident #005's SDM had requested that the device be utilized at specified times in an attempt to prevent further falls from occurring. No approval related to the usage of the specified assistive device as a PASD was observed prior to the SDM's request, despite the device being in use since the resident was admitted to the home.

During separate interviews, RPNs #119, #121 and #122 and RN #108 indicated there had been no education or guidance in the home regarding the utilization of PASDs. RPNs #119, #121 and #122 and RN #108 further indicated no residents had a focus, goals or interventions listed in their plan of care related to the usage of a PASD, as staff were unaware of what constituted a PASD, what was required prior to the usage of a PASD or what assessments were required related to the utilization of a PASD. RPNs #119, #121 and #122 and RN #108 indicated that the specified assistive devices utilized by resident #005 had not been considered to be PASDs in the home previously, therefore staff had not considered residents who utilized the same specified assistive devices to require an approval related to the usage of PASDs.

During separate interviews, ADOCs #100 and #102 indicated the expectation in the

home was for PASDs utilized by a resident to have a physician's approval prior to usage of the PASD. ADOCs #100 and #102 further indicated they were aware there had been confusion in the home regarding which devices were considered to be PASDs, and currently the specified assistive devices utilized by resident #005 were not included in resident's plans of care unless they were considered to be restraints, therefore the nursing staff had not obtained a physician's approval prior to utilizing the devices.

The licensee failed to ensure that resident #005's PASDs were approved by any of the professionals listed in the legislation prior to using the devices. [s. 33. (4) 3.]

5. The licensee has failed to ensure that resident #005's PASDs were consented to prior to utilizing the PASD.

During review of resident #005's health care record, Inspector #672 did not observe any consent from resident #005 or the resident's SDM related to resident #005's usage of the specified mobility aid as a PASD. An informed consent was documented on a specified date, related to the usage of the specified assistive device as a PASD, as resident #005's SDM had requested that the specified assistive device be kept in a specified position at identified times, in an attempt to prevent further falls from occurring. No informed consent related to the usage of the specified assistive device as a PASD was observed prior to resident #005's SDM request, despite the resident utilizing the specified assistive device as a PASD since the resident was admitted to the home.

During an interview, Inspector #672 reviewed the resident's health care record with RPN #122, who indicated resident #005 did not currently have an informed consent specific to the usage of the specified mobility aid as a PASD. RPN #122 further indicated that prior to an identified date, when resident #005's SDM requested the device be utilized at specified times in an attempt to prevent further falls from occurring, the resident had not had an informed consent in place related to the specified assistive device which was being utilized as a PASD. RPN #122 indicated that resident #005 had been utilizing the specified assistive device for PASD purposes since their admission to the home, but informed consent had bot been obtained until after resident #005's SDM request.

The licensee failed to ensure that resident #005's PASDs were consented to by the resident and/or their SDM prior to using. [s. 33. (4) 4.]

6. The licensee has failed to ensure that resident #004's PASDs were consented to prior to utilizing the PASDs.

During separate interviews, RPNs #119, #121 and #122 and RN #108 indicated there had been no education or guidance in the home regarding the utilization of PASDs. RPNs #119, #121 and #122 and RN #108 further indicated no residents had a focus, goals or interventions listed in their plan of care related to the usage of a PASD, as staff were unaware of what constituted a PASD, what was required prior to the usage of a PASD or what assessments were required related to the utilization of a PASD. RPNs #119, #121 and #122 and RN #108 indicated that the specified assistive devices utilized by resident #004 had not been considered to be PASDs in the home previously, therefore staff had not considered residents who utilized the same specified assistive devices to require an informed consent related to the usage of PASDs.

During separate interviews, ADOCs #100 and #102 indicated the expectation in the home was for PASDs utilized by a resident to have an informed consent prior to usage of the PASD. ADOCs #100 and #102 further indicated they were aware there had been confusion in the home regarding which devices were considered to be PASDs, and currently the specified assistive devices utilized by resident #004 were not included in resident's plans of care unless they were considered to be restraints to the resident, therefore the nursing staff had not obtained informed consent prior to utilizing the devices.

The licensee failed to ensure that informed consent for resident #004's usage of PASDs were received prior to using. [s. 33. (4) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure PASDs used to assist a resident with a routine activity of living is included in the resident's plan of care, is approved by any of the professionals listed in the legislation and is consented to, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #005's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated the fall resulted in the resident being transferred to the hospital and diagnosed with several injuries which required intervention.

Review of the licensee's internal policy related to Pain Assessment and Management indicated if pain was indicated, a comprehensive assessment was expected to be completed. The policy listed examples of indicators for completing a pain assessment and parameters to be included within the pain assessments.

Review of resident #005's written plan of care in place at the time of the fall indicated that resident #005 suffered from chronic pain related to several diagnoses. Interventions for resident #005's pain control included administration of pain medications and relaxation techniques. Resident #005's written plan of care specific to pain management did not appear to have been reviewed and revised following the fall listed within the critical incident report.

Review of resident #005's physician's orders from a specified period of time indicated resident #005 had several pain medications ordered and/or increased during that time.

Inspector #672 reviewed resident #005's progress notes from a specified period of time, which indicated that resident #005's pain appeared to be controlled until the fall listed within the critical incident report. Resident #005 returned from the hospital after the fall with a diagnosis of injuries and prescribed interventions. The progress notes indicated resident #005 was noted to be exhibiting signs and symptoms of pain upon return from hospital. During the review of the progress notes, resident #005 was also noted to be

exhibiting signs and symptoms of pain on nine separate occasions during the specified period of time and no comprehensive pain assessments were observed to have been completed.

Review of the completed comprehensive pain assessments for resident #005 during the specified period of time indicated that one assessment had been completed on a specified date, as part of resident #005's routine quarterly RAI-MDS assessment. No comprehensive pain assessments were observed to have been completed following resident #005's fall and injuries.

During separate interviews, PSWs #123 and #124 and RPN #122 indicated that resident #005 continued to struggle with uncontrolled pain following the fall listed within the critical incident report.

During separate interviews, RPNs #119, #121 and #122 indicated the expectation in the home was for the RNs and/or the RAI-MDS team to complete comprehensive pain assessments, and believed they were only required to be completed upon admission to the home and then on a routine quarterly basis. RPNs #121 and #122 further indicated the only pain assessments completed by the RPN staff were numerical pain assessments completed when a breakthrough analgesic was given, to assess the resident's pain level following administration of a pain medication.

During an interview, RN #108 indicated the expectation in the home was for the RPN staff to complete comprehensive pain assessments when a resident had a new complaint of pain or when interventions to assist with pain control had been ineffective. RN #108 further indicated the RAI team was responsible for completing comprehensive pain assessments upon admission to the home and then on a routine quarterly basis. RN #108 indicated the RN staff were not responsible to complete comprehensive pain assessments in the home.

During an interview, ADOC #102 indicated they were unsure of when comprehensive pain assessments were required to be completed for residents other than upon admission to the home and during routine quarterly assessments if the resident received pain medications.

During separate interviews, the RAI-MDS Coordinator and ADOC #100 indicated the expectation in the home was for the RPN staff to complete comprehensive pain assessments when a resident had a new complaint of pain, when an analgesic was

initiated, changed or discontinued or when interventions to assist with pain control had been found ineffective. ADOC #100 further indicated the pain management program was an area the management staff was working with the registered staff on, as they were aware there was a lot of confusion regarding when comprehensive pain assessments were required to be completed.

The licensee failed to ensure that when resident #005's pain was not relieved by initial interventions following a fall, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (2)]

2. The licensee has failed to ensure that when resident #004's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004. The CIR indicated that resident #004 had a specified assistive device at the head of the bed, which the resident had requested be disengaged. Before the specified assistive device could be disengaged, the resident was observed to have climbed up and over it, falling to the floor. Resident #004 was transferred to hospital following the fall and received an identified diagnosis which required specified treatment.

Review of resident #004's written plan of care in place at the time of the fall indicated that resident #004 suffered from chronic pain for identified reasons. The written plan of care in place following the fall indicated no new goals or interventions were implemented in an attempt to assist resident #004 with pain management strategies.

Review of resident #004's physician's orders from a specified period of time, indicated resident #004 had routine identified pain medications ordered prior to the fall to assist with chronic pain. Following the fall, resident #004 continued to have routine identified pain medications, along with another identified pain medication to be administered as needed for pain. During a specified period of time, resident #004 had their identified pain medications increased an identified number of times.

Inspector #672 reviewed resident #004's progress notes from a specified period of time which indicated that resident #004's pain appeared to be controlled until the fall sustained as indicated in the critical incident report. Resident #004 returned from the hospital with a specified diagnosis and prescribed intervention. The progress notes

indicated resident #004 was noted to be exhibiting signs and symptoms of pain upon return to the home from hospital. During the review of the progress notes, resident #004 was also noted to be exhibiting signs and symptoms of pain on 34 separate occasions during the specified period of time and no comprehensive pain assessments were observed to have been completed.

Review of the comprehensive pain assessments completed for resident #004 during the specified period of time indicated only one comprehensive pain assessment had been completed which indicated resident #004 had “satisfactory pain management therefore continue with current plan of care.”

During separate interviews, PSW #113 and RPNs #119 and #121 indicated that resident #004 struggled with uncontrolled pain on a daily basis following the fall outlined in the critical incident report.

During separate interviews, RPNs #119, #121 and #122 indicated the expectation in the home was for the RNs and/or the RAI-MDS team to complete comprehensive pain assessments, and believed they were only required to be completed upon admission to the home and then on a routine quarterly basis. RPNs #121 and #122 further indicated the only pain assessments completed by the RPN staff were numerical pain assessments completed when a breakthrough pain medication was given, to assess the resident’s pain level following administration of the pain medication.

During an interview, RN #108 indicated the expectation in the home was for the RPN staff to complete comprehensive pain assessments when a resident had a new complaint of pain or when interventions to assist with pain control had been ineffective. RN #108 further indicated the RAI team was responsible for completing comprehensive pain assessments for residents upon admission to the home and then on a routine quarterly basis. RN #108 indicated the RN staff were not responsible to complete comprehensive pain assessments in the home.

During an interview, ADOC #102 indicated they were unsure of when comprehensive pain assessments were required to be completed for residents other than during admission to the home and routine quarterly assessments when the resident received pain medications.

During separate interviews, the RAI-MDS Coordinator and ADOC #100 indicated the expectation in the home was for the RPN staff to complete comprehensive pain

assessments when a resident had a new complaint of pain, when a pain medication was initiated, changed or discontinued or when interventions to assist with pain control had been found ineffective. ADOC #100 further indicated the pain management program was an area the management staff was working with the registered staff on, as they were aware there was a lot of confusion regarding when comprehensive pain assessments were required to be completed.

The licensee failed to ensure that when resident #004's pain was not relieved by initial interventions following a fall, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose. [s. 52. (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 when any resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for that purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken to meet the needs of residents with identified responsive behaviours included assessment and documentation of the resident's responses to the interventions implemented.

Related to resident #001:

A Critical Incident Report was submitted to the Director regarding an alleged incident of resident to resident abuse which occurred between residents #001 and #002. Resident #001 sustained identified injuries as a result of the incident and resident #002 did not sustain any physical injuries. The CIR further indicated there had been several previous altercations between residents #001 and #002.

During record review, Inspector #672 reviewed resident #001’s written plan of care in place at the time of the incident which indicated that resident #001 was known to exhibit identified responsive behaviours with known triggers to the behaviours. The written plan of care provided interventions for staff to follow when resident #001 exhibited identified responsive behaviours.

Review of resident #001’s RAI-MDS assessment current at the time of the incident indicated resident #001 was noted to exhibit identified responsive behaviours and none of the noted behaviours were easily altered.

Review of resident #001's progress notes from a specified period of time indicated that resident #001 received non-scheduled medications an identified number of times to assist with decreasing exhibited responsive behaviours, was involved in a specified number of incidents of resident to resident and resident to staff altercations and was placed on an identified assessment a specified number of times for identified reasons.

During record review, Inspector #672 reviewed the identified assessments completed for resident #001 from a specified period of time. Upon review of the documentation, Inspector #672 observed the assessment had not been completed an identified number of times.

Inspector #672 then reviewed the identified assessments completed for resident #001 from another specified period of time. Upon review of the documentation, Inspector #672 observed the assessment had not been completed an identified number of times.

Related to resident #002:

Review of resident #002's MDS assessment in place at the time of the incident indicated that resident #002 was noted to have identified responsive behaviours which were not easily altered.

Inspector #672 then reviewed resident #002's health care record to observe if an identified assessment had been completed for the resident. Inspector observed that an identified assessment had only been completed for the resident upon their admission to the home, for a specified time period.

Review of resident #002's written plan of care in place at the time of the incident did not indicate that resident #002 had any exhibited responsive behaviours. Inspector #672 then reviewed the identified assessment completed upon resident #002's admission to the home and observed the assessment had not been completed an identified number of times.

During separate interviews, PSWs #109, #113. #123 and #124, all indicated the expectation in the home was for the documentation related to the identified assessments to be completed in full every time a resident was placed on the specified observation. PSW #109 indicated the identified assessments and other forms of documentation were routinely not completed by the PSW staff due to time constraints related to not having enough direct care staff members on the resident home areas to meet the resident's care needs.

During separate interviews, RPNs #119, #121, #122, RN #108 and the RAI-MDS Coordinator all indicated the expectation in the home was for the PSW staff to complete the identified assessments and documentation in full every time a resident was placed on the specified observation. At the end of each shift the registered staff were expected to review the identified assessment form to ensure it was completed in full and to follow up on any behaviour which may be documented on the form that was of concern.

During an interview, BSO RPN #110 indicated the expectation in the home was for the identified assessments and documentation to be completed in full every time a resident was placed on the specified observation. BSO RPN #110 further indicated it had been an ongoing challenge in the home for staff to complete the identified assessment forms in full, despite ongoing reminding, education and support from the BSO team. BSO RPN #110 indicated the nursing and management teams were aware of the ongoing challenges of the identified assessment forms regularly not being completed in full and

were attempting to work with the direct care staff to ensure the documents were completed in full when a resident was placed on the specified observation.

During separate interviews, ADOCs #100 and #102 indicated the expectation in the home was for the PSW staff to complete the identified assessments and documentation in full every time a resident was placed on specified observation. At the end of each shift the registered staff were expected to review the identified assessment forms to ensure they were completed in full and to follow up on any responsive behaviour which may be documented on the form that was of concern. ADOCs #100 and #102 further indicated that it had been an ongoing challenge in the home to get staff to complete identified assessment forms in full, despite ongoing reminding, education and support from the BSO team, and they were attempting to work with the direct care staff to ensure the documents were completed in full when a resident was placed on the specified observation.

The licensee failed to ensure that residents #001 and #002 were assessed and observations of the resident's responses to interventions implemented related to exhibited responsive behaviours were documented according to the directions listed on the identified assessment forms during multiple assessment periods. [s. 53. (4) (c)]

2. The licensee has failed to ensure that resident #003 was assessed and observations of the resident's responses to interventions implemented related to exhibited responsive behaviours were documented according to the directions listed on identified assessment forms, during multiple assessment periods.

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse which occurred between PSW #104 and resident #003.

During record review, Inspector #672 reviewed resident #003’s written plan of care in place at the time of the incident which indicated that resident #003 was known to exhibit identified responsive behaviours, with known triggers. The written plan of care provided interventions for staff to implement related to the resident’s exhibited responsive behaviours.

Review of resident #003’s RAI-MDS assessment current at the time of the incident indicated resident #003 was noted to have problems with both short and long term memory, cognitive skills for daily decision making were noted to be moderately impaired with poor decisions, therefore cues or supervision was required. Resident #003 was also

noted to exhibit several identified responsive behaviours which were easily altered and exhibit several identified responsive behaviours which were not easily altered.

Review of resident #003's progress notes from a specified period of time indicated that resident #003 was known to exhibit identified responsive behaviours but there were no documented incidents of resident to resident aggression documented during this time period.

During record review, Inspector #672 reviewed the identified assessments completed for resident #003 from a specified period of time. Upon review of the assessments, Inspector #672 observed the documentation had not been completed an identified number of times.

During separate interviews, PSWs #109, #113. #123 and #124, all indicated the expectation in the home was for the documentation related to the identified assessments to be completed in full when a resident was placed on a specified observation. PSW #109 indicated identified assessments and other forms of documentation were routinely not completed by the PSW staff due to time constraints related to not having enough direct care staff members on the resident home areas to meet the resident’s care needs.

During separate interviews, RPNs #119, #121, #122, RN #108 and the RAI-MDS Coordinator all indicated the expectation in the home was for the PSW staff to complete the identified assessments and documentation in full when a resident was placed on specified observation. At the end of each shift the registered staff were expected to review the identified assessment form to ensure it was completed in full and to follow up on any behaviour documented on the form that was of concern.

During an interview, BSO RPN #110 indicated the expectation in the home was for the identified assessments and documentation to be completed in full when a resident was placed on specified observation. BSO RPN #110 further indicated it had been an ongoing challenge in the home for staff to complete identified assessment forms in full, despite ongoing reminding, education and support from the BSO team. BSO RPN #110 indicated the nursing and management teams were aware of the ongoing challenges of identified assessment forms regularly not being completed in full and were attempting to work with the direct care staff to ensure the documents were completed in full when a resident was placed on specified observation.

During separate interviews, ADOCs #100 and #102 indicated the expectation in the

home was for the PSW staff to complete the identified assessments and documentation in full when a resident was placed on specified observation. At the end of each shift the registered staff were expected to review the identified assessment forms to ensure they were completed in full and to follow up on any responsive behaviour which may be documented on the form that was of concern. ADOCs #100 and #102 further indicated that it had been an ongoing challenge in the home to get staff to complete identified assessment forms in full, despite ongoing reminding, education and support from the BSO team, and they were attempting to work with the direct care staff to ensure the documents were completed in full when a resident was placed on specified observation.

The licensee has failed to ensure that resident #003 was assessed and observations of the resident's responses to interventions implemented related to exhibited responsive behaviours were documented according to the directions listed on identified assessment forms during a specified period of time. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that actions for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003's SDM was immediately notified upon becoming aware of an allegation of staff to resident abuse.

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse between PSW #104 and resident #003.

Inspector #672 reviewed the licensee's internal policy related to Prevention, Reporting and Elimination of Resident Abuse which indicated the definitions of each type of resident abuse and included examples of each.

Inspector #672 reviewed the internal investigation notes and the Critical Incident report related to the alleged incident of staff to resident abuse between PSW #104 and resident #003. The internal investigation notes indicated the allegation was founded and resident #003 had been abused by PSW #104. The notes further indicated RN #103 had not followed the licensee's internal prevention of abuse policy.

During an interview, ADOC #102 indicated they did not inform resident #003's SDM of the allegation of staff to resident abuse as they were not notified of the true extent of the

incident until the following week, after ADOC #100 had initiated the internal investigation. ADOC #102 further indicated they were in the home on the date of the incident but had only been informed that resident #003 was transferred to the hospital for assessment, but had not been told of the incident.

During the course of the inspection, RN #103 and RPN #106 were not available for interview, due to extended absences from the home.

During an interview, ADOC #100 indicated they were informed of the allegation of staff to resident abuse between PSW #104 and resident #003 from RN #108 on a specified date. ADOC #100 indicated RN #108 informed them that there had been a lot of gossip occurring on the resident home areas between staff members about what had occurred, which included confusion regarding the internal restraints policy and the internal abuse policy. ADOC #100 indicated they had not informed resident #003's SDM of the allegation when they became aware of the allegation, as they assumed RN #103, who had been present during the incident had informed resident #003's SDM. ADOC indicated that on a specified date, they contacted resident #003's SDM to discuss the resident's hospital stay and it was during that conversation resident #003's SDM indicated they had not been aware that an incident involving resident #003 had occurred or that resident #003 was currently residing in the local hospital. ADOC #100 further indicated they were aware of the internal policy and legislation which required that residents' SDMs must be immediately notified of any allegation upon the licensee becoming aware of the alleged incident of abuse.

During an interview, RN #108 indicated they did not inform resident #003's SDM of the allegation of staff to resident abuse as they were not present during the incident and only had second hand knowledge of the incident after listening to the gossip occurring within the home. RN #108 did indicate the gossip they were hearing about the incident concerned them, which was why the reported the allegations to ADOC #100 to further look into.

The licensee failed to ensure that resident #003's SDM was immediately notified of the incident of staff to resident abuse between PSW #104 and resident #003. Resident #003's SDM was not notified of the incident or that the resident was in the hospital until four days after the incident had occurred. [s. 97. (1) (a)]

2. The licensee failed to ensure that resident #003's SDM was notified of the outcome of the internal investigation into the alleged incident of staff to resident abuse.

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse between PSW #104 and resident #003.

Inspector #672 reviewed the internal investigation notes and the Critical Incident report related to the alleged incident of staff to resident abuse between PSW #104 and resident #003. The internal investigation notes indicated the allegation was founded and resident #003 had been abused by PSW #104.

During an interview, ADOC #100 indicated they were informed of the allegation of staff to resident abuse between PSW #104 and resident #003 from RN #108 on a specified date. ADOC #100 indicated the outcome of the internal investigation was the allegation of staff to resident abuse was founded, as the internal policies and procedures related to restraints and resident abuse were not complied with. ADOC #100 indicated RN #103 had gone off of work on an extended leave following the incident, therefore had been unable to follow up with them. ADOC indicated they had not contacted resident #003's SDM to discuss the outcome of the internal investigation due to not following up with RN #103. ADOC #100 further indicated they were aware of the internal policy and legislation which required that residents' SDMs must be notified of the outcome of internal investigations into any alleged incident of abuse.

The licensee failed to ensure that resident #003's SDM was notified of the outcome of the internal investigation into the incident of staff to resident abuse between PSW #104 and resident #003. [s. 97. (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 all resident's SDMs are immediately notified upon becoming aware of an alleged, suspected or witnessed incidents of abuse and are notified of the outcome of the investigation, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents #004, #007 and #008 as required, when the residents were receiving a specified medication therapy in the home.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #004. The CIR indicated that resident #004 had a specified assistive device at the head of the bed, which the resident had requested be disengaged. Before the specified assistive device could be disengaged, the resident was observed to have climbed up and over it, falling to the floor. Resident #004 was transferred to hospital following the fall and was admitted with a diagnosis of a specified injury which required an identified intervention.

During review of resident #004's progress notes from a specified period of time, Inspector #672 observed that on an identified date, resident #004 was assessed by the physician and a specified test was ordered to confirm an identified condition. On a specified date, the results were returned to the home and resident #004 was diagnosed with an identified condition, therefore the physician ordered a specified medication therapy for an identified number of days.

Inspector #672 reviewed resident #004's progress notes from a specified period of time and observed there was no documentation on an identified number of shifts regarding the resident's identified condition or assessments.

Further review of resident #004's progress notes from a specified period of time, showed that on an identified date, resident #004 was noted to have been diagnosed with another identified condition.

Review of resident #004's physician's orders indicated a specified medication therapy had been ordered for an identified number of days.

Inspector #672 reviewed resident #004's progress notes from a specified period of time and observed there was no documentation on an identified number of shifts regarding the resident's identified condition or assessments.

Further review of resident #004's progress notes from a specified period of time, showed that on an identified date, resident #004 was noted to have a significant increase in pain, accompanied by identified symptoms. Upon assessment from the RN, resident #004 was transferred to hospital for further assessment and was admitted for identified reasons. On a specified date, resident #004 returned to the home with a physician's order for a specified medication therapy for an identified number of days.

Inspector #672 reviewed resident #004's progress notes from a specified period of time and observed there was no documentation on an identified number of shifts regarding the resident's identified condition or assessments.

Inspector #672 then expanded the scope of the inspection to include two more residents who had recently received a specified medication therapy within the home, to determine if staff had recorded symptoms of the identified condition or assessments on every shift, as required. On a specified date, Inspector #672 was provided with the name of resident #007 from RPN #122 and the name of resident #008 from RPN #121, who indicated both residents had received a specified medication therapy within the home in the previous month.

Related to resident #007:

During review of resident #007's progress notes, Inspector #672 observed that on a specified date, resident #007 was observed to have an identified symptom, and had been complaining intermittently of not feeling well for the previous two weeks. On a specified date, resident #007 was assessed by the physician, who ordered specified tests. On a later specified date, resident #007 was noted to have specified symptoms and complaints of feeling unwell. The on-call physician was notified and a new order for a specified medication therapy was received for an identified number of days.

Inspector #672 reviewed resident #007's progress notes from a specified period of time and observed there was no documentation on an identified number of shifts regarding the resident's identified condition or assessments.

Related to resident #008:

During review of resident #008's progress notes from an identified period of time, Inspector #672 observed that on a specified date, resident #008 had a specified test. Resident #008 was then assessed by the nurse practitioner on a specified date, who decided to treat resident #008's identified condition with a specified medication for identified reasons.

Review of resident #008's physician's orders showed a new medication order for an identified therapy for a specified number of days.

Inspector #672 reviewed resident #008's progress notes from a specified period of time, and observed there was no documentation on an identified number of shifts regarding the resident's identified condition or assessments.

During separate interviews, RPNs #119, #121 and #122, RN #108, ADOCs #100 and #102 all indicated the expectation in the home was for staff to document on residents who were receiving a specified medication therapy on a shift by shift basis during the entire time the resident was receiving the specified medication therapy.

The licensee failed to ensure that staff on every shift recorded identified symptoms and assessments for residents #004, #007 and #008 as required when the residents were receiving a specified medication therapy in the home. [s. 229. (5) (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 on every shift, symptoms of infection are recorded, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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 failed to ensure that the results of the staff to resident abuse investigation involving resident #003 was reported to the Director.

A Critical Incident Report was submitted to the Director regarding an alleged incident of staff to resident abuse between PSW #104 and resident #003.

Inspector #672 reviewed the internal investigation notes and the Critical Incident report related to the alleged incident of staff to resident abuse between PSW #104 and resident #003.

During an interview, ADOC #100 indicated the outcome of the internal investigation was the allegation of staff to resident abuse was founded, as the internal policies and procedures were not complied with.

During review of the report to the Director, Inspector #672 did not observe any documentation related to the outcome of the internal investigation into the alleged incident of staff to resident abuse between resident #003 and PSW #104. The description of the incident outlined in the report to the Director, including the events leading up to the occurrence, also did not include specified information which had been deemed to be founded through the internal investigation, or that resident #003 was noted to have sustained identified injuries.

During the interview with ADOC #100, they indicated they were aware of the internal policy and legislation which required the Director to be notified of the outcome of all internal investigations into alleged incidents of resident abuse and neglect.

The licensee failed to ensure that the results of the internal investigation into the allegation of staff to resident abuse involving resident #003 and PSW #104 was reported to the Director. [s. 23. (2)]

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l’inspection :	2019_715672_0018
Log No. / No de registre :	017182-19, 017680-19, 017954-19, 020082-19, 020466-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 27, 2020
Licensee / Titulaire de permis :	The Corporation of the County of Northumberland 983 Burnham Street, COBOURG, ON, K9A-5J6
LTC Home / Foyer de SLD :	Golden Plough Lodge 983 Burnham Street, COBOURG, ON, K9A-5J6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Clare Dawson

To The Corporation of the County of Northumberland, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee shall ensure the following:

1) Develop and implement a plan to ensure that all front line staff members and others involved in the different aspects of the resident's care provide the care set out in the resident's plan of care for resident #005.

Please prepare and submit the written plan for achieving compliance for Inspection #2019_715672_0018 to Jennifer Batten, LTC Homes Inspector, MOLTC, by email to CentralEastSAO.MOH@ontario.ca by February 10, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that resident #005's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #005. The CIR indicated the fall resulted in the resident being transferred to hospital and diagnosed with injuries which required specified treatments. The CIR further indicated that at the time of the fall, resident #005 was receiving personal care while in the bed from PSW #125, with the bed elevated. PSW #125 walked away from the bed to secure personal care supplies and resident #005 fell. PSW #125 was providing personal care to the resident independently.

Review of resident #005's RAI-MDS Assessment in place at the time of the

incident indicated resident #005 had an identified exhibited responsive behaviour. The assessment further stated that resident #005 required extensive assistance from two staff members to physically assist with bed mobility and required total assistance from two staff members to physically assist with personal hygiene.

Review of resident #005's written plan of care in place at the time of the incident stated the resident had multiple risk factors related to falling and had sustained previous falls in the past. Resident #005 was considered to be at high risk for falling and had several interventions in place to assist in preventing falls from occurring. The interventions indicated resident #005's bed was to be in the lowest position for safety when staff were not providing care. Resident #005 required assistance from two staff members for the provision of care including bed mobility.

During an interview, PSW #124 indicated resident #005 required two staff members to provide personal hygiene and that the bed should always be placed in the lowest position when a staff member was not at the bedside to prevent the resident from falling.

During an interview, RPN #122 indicated resident #005's bed should always be in the lowest position when a staff member was not at the bedside to prevent the resident from falling. The expectation in the home was for the resident's plan of care to be followed at all times regarding the amount of staff members required to assist in providing activities of daily living to the resident.

PSW #125 was not available for interview during this inspection.

During an interview, ADOC #100 indicated that an internal investigation into resident #005's fall had found that at the time of the fall, PSW #125 raised resident #005's bed while providing personal care. ADOC #100 further indicated that PSW #125 had been providing personal hygiene care to resident #005 independently and stepped away from resident #005's bed to obtain personal care supplies without lowering the bed. ADOC #100 indicated the expectation in the home was for every residents' plan of care to be provided to the resident as specified in the plan. ADOC #100 further indicated resident #005 should have had two staff members present to provide personal care as indicated in resident

#005's plan of care and PSW #125 should have lowered the bed prior to walking away from the bedside.

The licensee failed to ensure that resident #005's plan of care was provided to the resident as specified in the plan when the required number of staff members indicated in the resident's plan of care to provide assistance with personal hygiene had not been implemented and the bed was not lowered when the staff member walked away from the resident's bedside to secure personal care supplies.

The severity of this issue was determined to be a level 3, as there was actual harm to resident #005. The scope was determined to be isolated, at level 1, as one out of three incidents reviewed demonstrated that care was not provided to residents as specified in the plan. The history related to non-compliance with LTCHA, 2007, s. 6 (7) was determined to be a level 3, with four previous incidents of non-compliance to the same subsection noted, as follows:
A Voluntary Plan of Compliance was issued during Inspection #2018_694166_0003.
A Voluntary Plan of Compliance was issued during Inspection #2017_603194_0027.
A Voluntary Plan of Compliance was issued during Inspection #2017_603194_0010.
A Written Notification was issued during Inspection #2016_397607_0016.
(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2020

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 Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère 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 27th day of January, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Jennifer Batten

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