Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Dec 4, 2018	2018_543561_0018	027724-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Hamilton Continuing Care
125 Wentworth Street South HAMILTON ON L8N 2Z1

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

DARIA TRZOS (561), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 23, 24, 25, 26, 30, 31, 2018 and November 1, 2, 7, 8, 9, 13, 14, 2018.

The following Complaint inspections were completed concurrently with this Resident Quality Inspection (RQI):
009064-18 - related to falls with injury,
024757-18 - related to staffing and housekeeping

The following Critical Incident System (CIS) inspections were completed concurrently with this RQI:
027527-17 - related to falls,
028361-17 - related to alleged abuse,
002877-18 - related to alleged neglect,
025248-18 - related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Acting General Manager (GM), former GM, Director of Nursing Care (DONC), Neighbourhood Coordinator, Administrative Coordinator, Director of Food Services, Registered Dietitian (RD), Maintenance Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide, Resident Council President, residents and families.

During the course of the inspection, the inspectors observed the meal services and snack services, observed the provision of care, observed medication pass, reviewed clinical records, investigation notes, Resident Council meeting minutes, training records, policies and procedures and any relevant documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
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
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **18 WN(s)**
- **8 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. 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 failed to ensure that residents were protected from abuse by anyone and

free from neglect by the licensee or staff in the home.

A) The Long Term Care Homes Act, 2007, defines neglect as failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2018, related to alleged staff to resident neglect. The CI indicated that resident #019 returned from the hospital on an identified date in 2018, and did not receive care until the next shift arrived.

The investigation notes were reviewed during this inspection and identified that resident #019 returned from the hospital at the beginning of an identified shift and care was not provided to the resident until the next shift arrived.
The investigation concluded that resident #019 was neglected by PSW #128 as the resident was assigned to them and they failed to provide the care.

PSW #135 was interviewed by the LTCH Inspector #561, and stated that before the end of their shift they informed PSW #128 and PSW #134 that resident #019 had not been provided care and requested that care be provided.
PSW #134 was interviewed and stated that they recall going into resident #019's room to provide care; however, the resident refused and that PSW #128 reported that they attempted to provide care, but the resident refused.
PSW #128 could not be interviewed.

Registered staff #127 was interviewed by the LTCH Inspector #561, and stated that they assessed the resident's vitals but did not complete the head to toe assessment on their shift. The registered staff stated they were not aware that care was not provided to the resident on their shift and that PSW #128 was responsible for the resident's care. When the next shift arrived, they noticed that the care was not provided to the resident.

Resident #019 could not be interviewed.

The former General Manager of the home who completed the investigation, was interviewed by the LTCH Inspector #561. They stated that resident #019 was neglected by staff in the home when care was not provided after the resident returned from the hospital. PSW #128 was responsible for providing care to resident #019 when they

returned, as this resident was on their assignment. The former GM stated that the registered staff did not complete a head to toe assessment until the next shift arrived. Resident #019 was re-admitted from the hospital on an identified date. The PSW staff were aware that resident returned from the hospital; however, they failed to provide care to the resident. The registered staff did not do a head to toe assessment, did not monitor the resident's condition. One of the PSWs stated that they attempted to provide care to the resident; however, they refused. This was not reported to the registered staff nor documented in clinical records. The PSW who was accountable for resident #019's care on the shift, did not provide care to the resident; however, they documented in POC that care was provided to them.

The former GM stated that based on the investigation resident #019 was neglected by staff in the home.

The licensee failed to ensure that resident #019 was protected from neglect by the home or staff in the home.

This area of non compliance was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI.

B) The Long Term Care Homes Act, 2007, defines financial abuse as any misappropriation or misuse of a resident's money or property.

A CIS report was submitted to the Director on an identified date in 2018, of an allegation of an incident of alleged abuse towards resident #020 which was reported by their Substitute Decision Maker (SDM). The SDM reported to the home this happened during an identified activity with a staff member. The Neighbourhood Coordinator had a discussion with the identified staff member after the meeting. The CIS report also stated that resident #012 had reported another incident with the staff member.

LTCH Inspector #581, interviewed the Acting GM and the Administrative Coordinator and LTCH Inspector #561, interviewed the Acting GM, the Neighbourhood Coordinator and the Administrative Coordinator during this inspection. In an interview with the Inspector #581, the Acting GM confirmed that incidents occurred with the identified staff member on multiple occasions with different residents.

During an interview with the Inspector #561, the Neighbourhood Coordinator stated that the home did an investigation and identified that there were numerous occasions with the

staff member identified that occurred to multiple residents. The home had the police involved and they initiated an investigation which is ongoing. The identified staff member could not be interviewed.

The employee file was reviewed by the LTCH Inspector and contained a letter identifying a prior incident in 2016 and that the employee was to follow the homes policies and procedures in the future.

LTCH Inspector #561 attempted to interview residents that reported incidents in the CI. Resident #020 was not able to be interviewed. Resident #021 was interviewed and was not able to recall the situation. Resident #012 was interviewed and stated that there was an incident several months ago.

During the interview with the Acting GM, they stated they believed the identified staff member abused the identified residents.

The licensee failed to ensure that residents were protected from abuse by anyone.

This area of non-compliance was identified during a CIS inspection log #025248-18, conducted concurrently with this RQI. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

Resident #005 was observed wearing glasses during this inspection. PSW #114 was interviewed and stated that the resident wore reading glasses during the day.

The MDS quarterly assessments indicated that resident #005 had impaired vision.

The written plan of care was reviewed and indicated that resident had vision loss; however, did not indicate that the resident wore reading glasses.

The RAI Coordinator was interviewed and stated that the resident wore glasses and required them daily. The RAI Coordinator confirmed that this should have been included in the written plan of care.

The licensee failed to ensure that the written plan of care set out the planned care for the resident related to vision. [s. 6. (1) (a)]

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

A) Resident #008 was admitted to the home on an identified date in 2018. The Continence assessment on Admission was conducted and indicated that the resident had a specific level of continence for bladder functioning. A review of the Minimum Data Set (MDS) assessment section H. Continence in last 14 days identified resident #008 had a different level of bladder continence and there was no change in urinary continence in the past 90 days. Review of the Resident Assessment Protocol (RAP) during the same time period indicated the level of continence as documented in the MDS assessment. During an interview with the DONC they verified the level of continence and confirmed that the MDS assessment and the Admission Continence Assessment were not integrated and consistent with each other.

The home did not ensure that staff and others involved in the continence assessments of resident #008 collaborated with each other in the continence assessment of the resident, so that assessments were integrated, consistent with and complemented each other. (632)

B) A review of the MDS assessment completed on an identified date in 2018, identified resident #009 had a level of bladder continence and review of the Resident Assessment Protocol (RAP) during the same time period indicated the resident had a different level of bladder continence.

The MDS assessment on an identified date in 2018, indicated the level of continence as documented on the previous RAP and there was no change in urinary continence in the past 90 days.

During an interview with the DONC and review of the plan of care verified the continence status and confirmed that the MDS assessment and the RAP were not integrated and consistent with each other.

C) A review of a CIS report submitted on an identified date in 2017, identified that resident #014 had a fall and was transferred to hospital with a deterioration in their overall condition and was diagnosed with a condition and an injury.

Review of the Falls Incident Report assessment identified that resident #014 fell on an identified date in 2017. Review of the MDS assessment completed after the fall did not identify the resident fell in the past 30 days. In an interview with the DONC, they confirmed that the MDS assessment and the post fall assessment were not integrated and consistent with each other.

This area of non-compliance was identified during a CIS Inspection log #027527-17,conducted concurrently with this RQI. [s. 6. (4) (a)]

3. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A) Resident #010 with identified conditions was observed not being offered identified products during lunch observation. Interview with PSW #109, identified that the staff referred to the Meal Service Report to provide additional nutrition interventions to the residents and identified products were not offered to resident #010 as this intervention was not included into the Report. Review of resident #010 written plan of care indicated in diet orders intervention that the resident was to be offered the identified products at meals and snacks.

Interview with the Director of Dietary Services identified that any updates to the resident's nutrition plan of care were to be documented in the Registered Dietitian Visit Report and offering products at meals and snacks to resident #010 was not documented as a nutritional intervention. The RD identified that based on the resident's plan of care records, the identified products were recommended by the RD on an identified date in 2017.

The home failed to ensure that the staff and others who provided direct care to resident

#010 were kept aware of offering products to the resident and did not have convenient and immediate access to the updated version of the Meal Service Report.

B) Resident #011 had a nutrition intervention of providing a specific item at the afternoon snack which was not implemented from the date of its initiation up until this inspection, which was confirmed by Dietary Aid (DA) #111. Review of Snack Service Report did not contain information about providing the specific item during afternoon snack for resident #011.

Interview with the Director of Dietary Services, identified that any updates to the resident's nutrition plan of care were to be documented in the Registered Dietitian Visit Report and offering the specific item during afternoon snacks to resident #011 was not documented as a nutritional intervention. The RD identified that based on the resident's plan of care records, the identified item at the afternoon snack was recommended by the RD on an identified date in 2017.

The home failed to ensure that the staff and others who provided direct care to resident #011 were kept aware of providing the specified item during afternoon snacks to the resident and did not have convenient and immediate access to the updated version of the Snack Service Report. [s. 6. (8)]

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

A) Resident #005 had a plan of care indicating they had altered skin integrity since an identified date in 2018.
The clinical record review indicated that the altered skin integrity healed on an identified date in 2018.

The PSW #114 was interviewed and stated that the resident did have a skin issue which had healed. LTCH Inspector #561 along with the PSW observed the resident's skin and there were no open areas.

The current written plan of care was reviewed and indicated that the resident had the altered skin integrity with interventions in place for the treatment. The written plan of care was not revised when the altered skin integrity had healed.

In an interview with the DONC, they indicated that the resident's altered skin integrity had healed and the written plan of care should have been revised to reflect that.

The licensee failed to ensure that the written plan of care was revised when the resident's care needs changed and care set out in the plan of care was no longer necessary for the alteration in the skin integrity.

B) Resident #012 had a plan of care indicating they had multiple issues with altered skin integrity on an identified date in 2018. The treatment was initiated and the weekly skin assessments were completed. The weekly skin assessment indicated that the skin was clear. The review of the Electronic Treatment Administration Record (ETAR) indicated that the treatment was still in place and staff were documenting that they were providing the treatment. The interview with the RPN #107 indicated that the skin had healed and the treatment was no longer required; however, registered staff continued to document that they were providing treatment as the order continued to be in place. The RPN stated that the physician should have been notified and discontinue the treatment.

C) On an identified date in 2018 the weekly skin assessment for resident #002 indicated that they had altered skin integrity. The treatment was initiated as per the physician order. The weekly skin assessments indicated that the altered skin integrity healed on an identified date in 2018. The ETAR was reviewed and indicated that the staff were signing for treatments being administered when the skin was clear. The RPN #107 stated that the physician should have been notified to discontinue the order as it was no longer needed.

In an interview with the DONC, they stated that once the altered skin integrity had healed the registered staff should have called the physician to discontinue the order for the treatment and should have removed it from the ETAR.

The licensee failed to ensure that the plans of care were reviewed and revised when the residents' care needs changed and the care set out in the plans were no longer necessary. [s. 6. (10) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; to ensure that the resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

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

A) O. Reg 79/10, s. 114(1), states that the licensee must ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The policy titled "Medication Pass", last revised January, 2017, stated that staff were to administer medications ensuring that oral medications had been swallowed, not to leave the medications at bedside and not to ask anyone else to administer the medications.

On an identified date in 2018, the LTCH Inspector #561, observed medication administration. Registered staff #105 was observed to administer a medication in a specific way as indicated in the plan of care. Resident #004 was not monitored and the Inspector observed the resident not taking all the medication. Registered staff #105 did not remain with the resident to ensure that the resident swallowed all their medications. The registered staff continued to administer medications to other residents. LTCH Inspector reported to the registered staff that the resident did not take all their medications. The registered staff checked the cup and acknowledged that the resident did not take the medications.

The DONC was interviewed, and indicated that the registered staff should have stayed with the resident in the dining room and monitor to ensure that the resident swallowed all the medications.

The licensee has failed to ensure that the policy titled Medication Pass was complied with.

B) O. Reg. 79/10 s. 50(2) (a) indicated that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital. O. Reg. 79/10 s. 36 states that every licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The home's process for re-admission from hospital indicated that for residents that return from hospital stay longer than 24 hours, the registered staff were to complete a head to toe skin assessment on the evening shift (1400 hours – 2200 hours) and to complete a transfer and lift assessment when resident returns on your shift. Both assessments were to be completed and documented in PCC. The home had a form that staff fill out for readmission called Nursing Re-Admission Checklist as part of the process.

Resident #019 was re-admitted to the home from hospital on an identified date in 2018. The clinical record review identified that the transfer and lift assessment was not completed and the head to toe assessment was not completed upon return.

The interview with the registered staff #127, who worked on the shift when resident returned from the hospital, identified that the readmission process was not followed for resident #019.

The DONC was interviewed and confirmed that the process for re-admission was not followed by registered staff.

The home failed to ensure that the re-admission process was complied with.

This area of non-compliance was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI.

C) The home's process for staff lead resident offsite activities which involved resident's funds was identified by the former GM. It was identified that specific staff members were authorized to remove funds from the individual residents' trust accounts for the purpose of the outing and charges incurred. On return from the outing the staff member would then return all remaining resident funds and receipts to the Administrator Coordinator to be credited to the individual residents' trust account.

A CIS report was submitted to the Director on an identified date in 2018, related to an incident during an outing with residents and staff member #137. The Neighbourhood Coordinator had a discussion with the staff member #137 regarding the process in the home. The CI indicated that the staff member #137 did not follow the process as required.

The Administrative Coordinator, the Acting General Manager and the Neighbourhood Coordinator were interviewed, and confirmed that the staff member #137 failed to follow the home's process.

The licensee failed to ensure that the home's process for taking residents out to offsite activities was followed.

This area of non-compliance was issued during a CIS inspection log #025248-18, conducted concurrently with this RQI. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication response system was easily accessed and used by residents at all times.

A) Resident #011 was observed during this inspection, and the resident's call bell was observed not within reach. On both occasions the call bell was observed by LTCH Inspector #561 behind the resident's bed.

Resident #011 had a plan of care indicating that they were required to have a call bell placed within reach while in bed.

PSW #106 was interviewed and stated that the call bell should have been placed within reach of the resident.

The licensee failed to ensure that the resident-staff communication response system was easily accessed and used by residents at all times.

B) Resident #005 was observed during this inspection, and the resident's call bell was observed not within reach. On both occasion the call bell was observed by LTCH Inspector #561 on the floor.

The resident #005 had a plan of care indicating that they required to have a call bell placed within reach.

PSW #114 was interviewed and stated that the call bell should have been placed within reach of the resident.

In an interview with the DONC, they confirmed that the call bell should have been placed within the reach of the resident.

The licensee failed to ensure that the resident-staff communication response system was easily accessed and used by residents at all times. [s. 17. (1) (a)]

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 resident-staff communication response system is easily accessed and used by residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

A CIS report was submitted to the Director on an identified date in 2018, of an alleged abuse of four residents by staff member #137. The CI indicated that during a care conference with a family member they stated that staff member #137 abused resident #020. The CI was not submitted to the Director once the allegation was made in 2018. The CI also indicated that on a different date in 2018 staff member #137 allegedly abused other residents.

The home's policy titled "Prevention of Abuse and Neglect", Tab 04-06, indicated that any suspicion of abuse of a resident and identified the different types of abuse, was required to be immediately reported to the Director.

The DONC and the acting General Manager acknowledged that this incident was not immediately reported to the Director when the home first became aware of the suspicion of abuse.

The licensee failed to ensure that the alleged abuse of residents in the home by the staff member were immediately reported to the Director.

This area of non compliance was identified during a CIS inspection log #025248-18, conducted concurrently with this RQI. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately reporte the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #002 had a plan of care indicating the resident had an altered skin integrity acquired in the home in 2018. The clinical care records were reviewed during this inspection and indicated that the treatment was initiated. The Electronic Treatment Administration Record (ETAR) was reviewed for the identified month and there was no documentation identifying that the treatment was changed on an identified date in 2018.

The resident also had an order in place to monitor the dressing daily and change if needed. This was added to the ETAR for registered staff to document daily. The ETAR indicated that the registered staff failed to document that the dressing was monitored on several dates. The interview with the registered staff #105 indicated that the monitoring of the dressing was completed; however, the registered staff forgot to document this in ETAR.

The DONC was interviewed and acknowledged the missing documentation.

B) Resident #012 had a plan of care indicating they had altered skin integrity. On an identified date, the skin assessment was reviewed and the full description of the wound in the assessment tool was not documented. The skin assessment was blank.

C) Resident #002 had a plan of care indicating that they had altered skin integrity acquired in the home on an identified date in 2018. The weekly skin assessment on an identified date in 2018 was reviewed and the skin assessment was not fully documented in the tool used by the home.

D) The clinical records for resident #019 indicated that they were readmitted from the hospital on an identified date in 2018. The head to toe assessment and the skin section on the 24 hour care plan readmission form did not have a full description of the altered skin integrity.

The home's policy titled "Skin and Wound Care Program", tab 04-78, stated that the registered team member was to conduct an assessment and document that assessment using the online forms in PCC.

The interview with the DONC indicated that the registered staff were to fully document a skin assessment in PCC. The DONC confirmed that the above wound assessments were not fully documented including detailed description of the altered skin integrity.

The licensee failed to ensure that the assessments and reassessments of the residents' skin integrity were documented.

Non-compliance under point (D), was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and 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. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) An anonymous complaint was submitted to the MOHLTC on identified date in 2018 related to staffing.

Review of the plan of care for resident #010, identified that the resident required total assistance from staff. Review of Documentation Survey Report v2 from an identified period of time, identified that resident #010 had bathing support on two days for showering and it was coded as "NA" (Not Applicable) on an identified date in 2018 by staff #132.

Interview with staff #132, indicated that the staff member coded "NA" or "8 – activity did not occur", when there was a shortage of staff and the resident was provided partial bathing but not a full bath or shower. On an identified date in 2018, bathing support

and/or support action in Documentation Survey Report v2 was coded as "8 – activity did not occur" and as "NA" on another day in 2018 by staff #116. Interview with staff #116 indicated that they do not remember the reason why bathing support was coded as "NA" or as "8 – activity did not occur" in Documentation Survey Report.

Review of the Daily Staffing Roster and Schedule Worksheet for an identified period of time in 2018, identified that PSWs had full coverage during the day shift on the identified dates, which was confirmed by Administrative Coordinator and acknowledged by the General Manager.

This area of non-compliance was identified during a Complaint inspection log #024757-18, conducted concurrently with this RQI.

B) An anonymous complaint was submitted to the MOHLTC on an identified date in 2018 related to staffing.

Review of the plan of care for resident #026, identified that the resident required total assistance by PSW staff during bath (tub), bed bath. Review of Documentation Survey Report v2 for an identified period of time in 2018, identified that resident #026 had bathing support for bathing and it was coded as "8 – activity did not occur" on identified date in 2018 by staff #131.

Interview with staff #131, indicated that they coded "8 – activity did not occur", when there was a shortage of staff and the resident was provided partial bathing but not a full bath or shower. On multiple dates in 2018, bathing support and/or support action in Documentation Survey Report v2 was coded as "NA" by staff #132. Interview with staff #132, indicated that the staff member coded "NA", when there was a shortage of staff and the resident was provided partial bathing but not a full bath or shower.

Review of the Daily Staffing Roster and Schedule Worksheet for the period of time identified in 2018, identified that PSWs had full coverage on the first floor during the day shift on the identified dates, which was confirmed by Administrative Coordinator and acknowledged by the General Manager.

Clinical record review and the interview with the Administrative Coordinator confirmed that the home was fully staffed on the days identified above and confirmed resident #026 was not bathed, at minimum, twice a week by the method of their choice.

This area of non-compliance was identified during a Complaint inspection log #024757-18, conducted concurrently with this RQI. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Resident #012 had a plan of care indicating they had altered skin integrity acquired in the home in 2018. The treatment was initiated and the weekly skin assessments were completed. The skin assessment on an identified date in 2018, indicated that the skin was clear. The skin assessment on an identified date in 2018, indicated that resident #012 had altered skin integrity which was documented under 'other' section in the weekly skin assessment and not under 'pressure ulcer' section. There was no description of the wound in that section. The home's protocol for the altered skin integrity was not initiated on the identified date in 2018. The weekly skin assessment after the initial date indicated that the altered skin integrity deteriorated.

The RPN #107 was interviewed and indicated that resident #012 had the altered skin integrity and made a mistake by documenting it under the 'other' section. The RPN stated that the home does have a protocol in place for the initial altered skin integrity and was it not initiated on that date in 2018.

In an interview with the DONC, they confirmed that the home had a protocol in place for altered skin integrity and confirmed that the protocol was not initiated for resident #012 when they were assessed on the identified date in 2018 and they did not receive the treatment to promote healing.

The licensee failed to ensure the resident exhibiting altered skin integrity received immediate treatment and interventions to promote healing. [s. 50. (2) (b) (ii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On an identified date in 2018, during an observation of the medication pass the medication cart was observed unlocked. Registered staff #105 administering medications to residents in the dining was leaving the medication cart unlocked in between med pass for residents sitting in the dining room. The registered staff #105 acknowledged that the medication was unlocked a few times in between administration of medications to residents in the dining room.

The policy titled "Medication Pass", last revised January 2017 indicated not to leave the medication cart unattended at any time unless all medications are securely locked.

The DONC acknowledged, that the medication cart should always be locked when unattended. [s. 129. (1) (a)]

2. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On an identified date in 2018, during medication pass observation the narcotic bin in the medication cart on the lowest drawer was observed to be unlocked. Registered staff #105 was observed to be locking the medication cart; however, the narcotic bin was not locked. The registered staff was interviewed and stated that the expectation was for the narcotics to be double locked. The DONC was interviewed and confirmed that the staff were to ensure that the narcotic bin was always locked in the locked medication cart.

The policy titled "Medication System", revised January 2017, stated that narcotics and controlled substances must be stored in a double locked cabinet in the medication cart or in the medication room.

The licensee failed to ensure that the controlled substances were stored in a locked area in the locked medication cart. [s. 129. (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 drugs are stored in an area or a medication cart, that is secure and locked and to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy at the time of the incident, titled "Zero Tolerance of Resident Abuse and Neglect Program", policy number RC-02-01-01, updated April 2017, stated that the staff must complete an internal incident report and notify their supervisor of any alleged or witness abuse.

A CIS report was submitted to the Director on an identified date in 2018, related to alleged staff to resident #019 neglect.
The clinical record review identified that the incident report was not completed for this incident.
The DONC was interviewed and acknowledged that the internal incident report was not completed for this alleged incident of neglect.

The licensee failed to ensure that the home's Zero Tolerance of Resident Abuse and Neglect Program was complied with.

This area of non-compliance was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI. [s. 20. (1)]

WN #11: 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 abuse or neglect investigation were reported to the Director.

The home submitted a CIS report with an alleged neglect of resident #019 by staff. The investigation notes were reviewed and indicated that resident #019 returned from the hospital on an identified date in 2018, and did not receive any care until the next shift arrived.
The investigation concluded that the resident #019 was neglected by staff.
The CIS report was reviewed and did not provide any details of the outcome of the investigation. The former General Manager was interviewed, who completed the investigation of the incident, and acknowledged that the results of the investigation were not submitted to the Director.

The licensee failed to ensure that the results of the abuse and neglect investigation were reported to the Director.

This area of non-compliance was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI. [s. 23. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to keep a written record relating to each evaluation under clause (3) (e) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

An anonymous complaint was submitted to the MOHLTC on an identified date in 2018 related to staffing. Review of the Sufficient Staffing Audit form provided by the home, contained scores corresponding to Indicators and no names of the persons, who participated in the evaluation, no summary of the changes made and no date those changes were implemented.

Interview with the General Manager, indicated that the evaluation was to be conducted by the previous General Manager of the home and no additional information about Sufficient Staffing program evaluation was provided.

The home failed to keep a written record relating to each evaluation under clause (3) (e) that included the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented.

This area of non-compliance was identified during a Complaint inspection log #024757-18, conducted concurrently with this RQI. [s. 31. (4)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

Resident #005 was observed wearing glasses on two different dates in 2018. The resident`s glasses were not labeled. PSW #114 was interviewed and stated that the resident wore reading glasses during the day.

The home's policy titled "Personal Care Ware", policy number 06-02, stated that all personal ware is labeled with the resident`s name and / or room number.

In an interview with the DONC, they confirmed that the resident`s glasses should have been labeled.

The licensee failed to ensure that the resident had their glasses labelled. [s. 37. (1) (a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations

Review of the Resident Council minutes on a specific date in 2018, identified a concern related to a change in a menu item. During an interview with the DONC stated the concern was brought forward to the Director of Food Service but confirmed there was no response in writing to the Residents' Council in 10 days. [s. 57. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee did not ensure that each resident was offered a minimum of a snack in the afternoon and evening.

On an identified date 2018, it was observed during the snack distribution that resident #005 was not offered an afternoon snack. Review of the written plan of care indicated in diet and fluid order in interventions section that resident #005 was on regular diet and identified texture. Interview with PSW #116 identified that afternoon snack was not offered to the resident. Interview with the Director of Dietary Services, identified it was the home's expectation to offer a snack to residents during the afternoon snack, which was acknowledged by the General Manger and DONC.

The licensee did not ensure that resident #005 was offered a minimum of a snack in the afternoon. [s. 71. (3) (c)

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

A CIS report was submitted to the Director on an identified date of potential abuse towards residents #015, #016, #017 and #018 which occurred on an identified date in 2017. Initial CIS was submitted to the MOHLTC 22 days after the day of the licensee becoming aware of the incident of potential abuse.

Interview with the Acting GM, indicted that they did not have access to the Critical Incident System at the time of the incident.

Review of the electronic records provided by the DONC indicated that DONC had access to the Critical Incident System in 2017, but was not involved into the submission of this CI Report to meet ten days timeline of initial submission of the report.

The home failed to make the CIS report within 10 days of becoming aware of potential abuse.

This area of non-compliance was identified during a CIS inspection log #028361-17, conducted concurrently with this RQI. [s. 104. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The annual evaluation of the Medication Management System Program for year 2017, was reviewed by LTCH Inspector #561. The evaluation did not include the Registered Dietitian (RD). The DONC was interviewed and stated that the RD did not attend the annual evaluation of the Medication Management System Program. [s. 116. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the records of every former resident of the home were kept at the home for at least the first year after the resident was discharged from the home.

A CIS report was submitted to the Director on an identified date in 2018, related to alleged staff to resident #019 neglect. The electronic records in PCC indicated that resident #019 was discharged from the home in 2018. The LTCH Inspector #561 requested the hard copy of the resident's chart and the home was not able to provide it as it was not stored in the home. The RQI team had exited the home and the chart had not yet arrived in the home. The Administrative Coordinator indicated that they kept discharged residents' chart offsite and was not sure why it was taking this long for the chart to arrive.

The licensee failed to ensure that the record of every former resident of the home was kept in the home for at least the first year after the resident was discharged from the home.

This area of non-compliance was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI. [s. 233. (2)]

Issued on this 30th day of January, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2018_543561_0018
Log No. / No de registre :	027724-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 4, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	Hamilton Continuing Care 125 Wentworth Street South, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Enesia Malapela

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 Long Term Care Homes Act, 2007,

Specifically the licensee must:
1.Ensure that resident #019, and any other resident in the home are protected from neglect upon return from hospital.
2.Ensure that the home reviews the process for re-admission of residents from hospital and ensure that PSWs #135, #134, and registered staff #127 and any specified nursing staff know what their role is in re-admission. The home shall keep records of this training.
3.Ensure that residents #020, #012, #021 and any other resident in the home are protected from abuse and neglect by anyone.
4. Review and identify all residents that sustained financial abuse during activities in the home and during outings by staff #137 since an identified date in 2018.
5. Reimburse all residents identified to have been subjected to financial abuse by staff #137. Keep written records of reimbursements.
6. Obtain signature of receipt of total reimbursements to residents.
7. Ensure receipts and change from outings are recorded and trust account records are updated.
8. Ensure there is an auditing process to ensure that when outings occur unused funds are returned to trust accounts.
9. Ensure that all staff involved in handling resident's money are educated on the home's policy related to the handling of resident's money during outings.
10. Ensure that the details of and results of the investigation are reported to the Director, specifically related to employee #137.

Grounds / Motifs :

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

The Long Term Care Homes Act, 2007, defines neglect as failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2018, related to alleged staff to resident neglect. The CI indicated that resident #019 returned from the hospital on an identified date in 2018, and did not receive care until the next shift arrived.

The investigation notes were reviewed during this inspection and identified that resident #019 returned from the hospital at the beginning of an identified shift and care was not provided to the resident until the next shift arrived.
The investigation concluded that resident #019 was neglected by PSW #128 as the resident was assigned to them and they failed to provide the care.

PSW #135 was interviewed by the LTCH Inspector #561, and stated that before the end of their shift they informed PSW #128 and PSW #134 that resident #019 had not been provided care and requested that care be provided.
PSW #134 was interviewed and stated that they recall going into resident #019's room to provide care; however, the resident refused and that PSW #128 reported that they attempted to provide care, but the resident refused.
PSW #128 could not be interviewed.

Registered staff #127 was interviewed by the LTCH Inspector #561, and stated that they assessed the resident's vitals but did not complete the head to toe assessment on their shift. The registered staff stated they were not aware that care was not provided to the resident on their shift and that PSW #128 was responsible for the resident's care. When the next shift arrived, they noticed that the care was not provided to the resident.

Resident #019 could not be interviewed.

The former General Manager of the home who completed the investigation, was interviewed by the LTCH Inspector #561. They stated that resident #019 was neglected by staff in the home when care was not provided after the resident returned from the hospital. PSW #128 was responsible for providing care to resident #019 when they returned, as this resident was on their assignment. The former GM stated that the registered staff did not complete a head to toe assessment until the next shift arrived.

Resident #019 was re-admitted from the hospital on an identified date. The PSW staff were aware that resident returned from the hospital; however, they failed to provide care to the resident. The registered staff did not do a head to toe assessment, did not monitor the resident's condition. One of the PSWs stated that they attempted to provide care to the resident; however, they refused. This was not reported to the registered staff nor documented in clinical records. The PSW who was accountable for resident #019's care on the shift, did not provide care to the resident; however, they documented in POC that care was provided to them.

The former GM stated that based on the investigation resident #019 was neglected by staff in the home.

The licensee failed to ensure that resident #019 was protected from neglect by the home or staff in the home.

This area of non compliance was identified during a CIS inspection log #002877-18, conducted concurrently with this RQI.

B) The Long Term Care Homes Act,2007, defines financial abuse as any misappropriation or misuse of a resident's money or property.

A CIS report was submitted to the Director on an identified date in 2018, of an allegation of an incident of alleged abuse towards resident #020 which was reported by their Substitute Decision Maker (SDM). The SDM reported to the home this happened during an identified activity with a staff member. The Neighbourhood Coordinator had a discussion with the identified staff member after the meeting. The CIS report also stated that resident #012 had reported another incident with the staff member.

LTCH Inspector #581, interviewed the Acting GM and the Administrative Coordinator and LTCH Inspector #561, interviewed the Acting GM, the Neighbourhood Coordinator and the Administrative Coordinator during this inspection. In an interview with the Inspector #581, the Acting GM confirmed that incidents occurred with the identified staff member on multiple occasions with different residents.

During an interview with the Inspector #561, the Neighbourhood Coordinator stated that the home did an investigation and identified that there were numerous occasions with the staff member identified that occurred to multiple residents. The home had the police involved and they initiated an investigation which is ongoing. The identified staff member could not be interviewed.

The employee file was reviewed by the LTCH Inspector and contained a letter identifying a prior incident in 2016 and that the employee was to follow the homes policies and procedures in the future.
LTCH Inspector #561 attempted to interview residents that reported incidents in the CI. Resident #020 was not able to be interviewed. Resident #021 was interviewed and was not able to recall the situation. Resident #012 was interviewed and stated that there was an incident several months ago.

During the interview with the Acting GM, they stated they believed the identified staff member abused the identified residents.

The licensee failed to ensure that residents were protected from abuse by anyone.

This area of non compliance was identified during a CIS inspection log #025248-18, conducted concurrently with this RQI.

The severity of this issue was determined to be a level 3 as there was actual harm to residents. The scope of the issue was a level 2 (pattern) as it related to several residents. The home had a level 4 history as they had a Compliance Order issued under the same section on October 18, 2016 (2016_267528_0020), complied on March 9, 2017. (561)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
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 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)
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 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 4th day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office