Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2016;	2016_336620_0009 (A1)	003306-16	Critical Incident System

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street BARRIE ON L4N 5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET BARRIE ON L4N 5L3

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Inspector reviewed and granted a licensee request for an extension to order #001 and #002.

Issued on this 29 day of April 2016 (A1)

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

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 16-19, 2016 and February 22-26, 2016

This inspection related to Critical Incidents (CI) of the following:

three incidents related to falls,

six incidents related to staff to resident verbal abuse,

five incidents of staff to resident neglect,

12 incidents of staff to resident physical abuse), and

one incident of resident to resident physical abuse.

A complaint inspection was conducted concurrently during this inspection. An immediate order was issued during this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Nursing and Personal Care (DOC), the Nurse Manager, the Food Services Manager, the Resident Care Administrative Assistant, the Human Resources Manager, the Nurse Practitioner (NP), the Physiotherapist, the Convalescent Care Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food

Service Aides, a Behavioural Services Ontario Consultant (BSO), Members of the Barrie Police Services, and residents and residents' family members.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, residents' plans of care, various policies/procedures/programs, observed the provision of care, resident to resident interaction, meal services, conducted staff interviews, and resident and family interviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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

- **11 WN(s)**
- **3 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted a Critical Incident (CI) report to the Director that alleged PSW#112 physically abuse resident #015 which resulted in an injury to the resident.

According to the report the resident PSW #112 also scolded them.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 received discipline.

Inspector #620 interviewed the DOC on February 16, 2016. The DOC stated that with respect to the allegation of physical abuse by PSW #112 toward resident #015, the allegation was substantiated. The DOC further stated that it was the home's expectation that residents were to be protected from abuse by staff and that in this CI, resident #015 was physically abused by PSW #112, and should not have been.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02 -01-04). The policy contained an effective date of July 2013. The policy also included the following statement from Ontario Regulation 99 of the LTCHA:

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The policy further stated that the home would ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

The DOC confirmed that the policy was outdated and that there was no documented review or analysis of the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04) since July of 2013. The DOC stated that it was the homes expectation that an analysis and review of the policy should have been done annually; this did not occur and should have.

Inspector #620 further reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04). The policy stated that the home would ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may have constituted a criminal offence.

The policy also advised staff to complete document, "VII-G-10.00(B) Reporting and Investigating Alleged Abuse Checklist". One of the checklist items advised staff to, "Notify Police services (911) for occurrences of assault or willful infliction of physical pain or injury, sexual assault, alleged fraud/theft if directed by the CEO.

In an interview with Inspector #620 on February 16, 2016, the DOC confirmed that they determined the physical abuse of resident #015 by PSW #112 to be reportable to the police; however, the police were not contacted because the police were only to be called when it was authorized by the CEO. They stated that the CEO would not authorize them to notify the police.

Inspector #620 interviewed the CEO on February 16, 2016. The CEO stated that all notifications to police, stemming from incidents occurring in the home, were to be authorized by them. The CEO stated that in the incident of physical abuse by PSW #112 toward resident #015 the police were not contacted because they considered it to be a waste of tax dollars. They further noted that all incidents of financial abuse are reported to the police; however, physical abuse is reported only if the incident results in serious injury. [s. 19. (1)]

2. The licensee failed to ensure that residents were not neglected by the license or staff.

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

The home submitted critical incident report to the Director. The CI report indicated that resident #016 had a fall which resulted in a significant change and required the resident to be admitted to the hospital.

A review of the homes investigation notes revealed that resident #016 sustained a fall and was injured.

The investigation notes also contained a typed statement from PSW #146 stating they were told by a staff member that resident #016 had used an assistive aid. A review of the resident #016's plan of care revealed an absence of any direction identifying how the resident's assistive aid was to be utilized.

Inspector #627 reviewed the home's policy titled, "Fall Prevention and Management-Fall Assessment and Follow-up." The Policy was out of date and had not been evaluated/updated since October 18, 2012.

The policy stated that registered staff were not to mobilize the resident, until a full head to toe assessment had been completed. The policy also advised staff to notify family/POA and Physician and/or NP of the fall.

A review of policy "#RC12-00-03- Head Injury Routine" revealed that following a known or potential head injury RN/RPN staff were expected to notify the Physician and/or Nurse Practitioner (NP) of the resident's current condition and any time resident's condition changed. Notify the resident's family/Power of Attorney for Personal Care immediately of the incident and condition of the resident.

The home's policy also required staff to document head injury assessments using form #RC-12-00-03-01 (Head Injury Assessment Record). The assessment form was intended to document the resident's blood pressure (BP), pulse, respirations, level of consciousness, orientation, limb movement, and pupillary response every 15 minutes for the first hour, then every 30 minutes for the next two hours, then every hour for the next four hours, then every four hours for the next 48 hours.

A review of the head injury assessment record for resident #016 revealed that the initial entry on the document was not completed in full. The record also showed that resident #016 was not assessed, as required, on five occasions within the first 30 hours following their injury.

Inspector #627 interviewed RPN #110 who stated they were the first to attend to resident #016 following their fall. RPN #110 stated that they called another RPN for assistance. Resident #016 was assisted and moved to a chair before a head to toe assessment was conducted. RPN #110 stated that another RPN completed the head to toe post fall assessment while the resident was sitting in a chair. The resident was then taken to their room and a head injury protocol was initiated. RPN #110 stated they did not complete all the required head injury assessments because the resident was sleeping. RPN #110 stated that they did not notify the RN, the NP or a Physician, of the injury, and did not notify the family of the fall.

Inspector #627 interviewed RPN #113, who cared for resident #016 during an evening shift. RPN #113 stated they felt the resident was oriented to person as they recognized that they were a staff member. RPN #113 stated that when they asked what time of the day and where they were, they incorrectly answered. RPN #113 stated they were told by another staff member that the resident had vomited. RPN #113 stated they did not call an RN, the NP or the Physician to report the vomiting or the confusion.

RPN #109, who cared for resident #016 during the night shift, stated they called RN #108 to report that the resident's increased blood pressure and that the resident had two episode of emesis. The RPN was told by the RN to monitor the resident.

During an interview, RN #108 stated that they were called to assess resident #016. It was reported to them that the resident's health condition had deteriorated. RN #108 stated they did not notify the NP or Physician of the elevated blood pressure or the continued emesis. They advised the RPN to monitor the resident.

RPN #107, who cared for resident #016 during the day shift, stated they were not told during report that resident #016 was on a head injury protocol during report; therefore, the resident had not been assessed as required. When RPN #107 learned of the head injury they assessed resident #016. They found the resident to be exhibiting acute signs of adverse health. RPN #107 called Emergency Medical Services, who arrived and transported resident #016 to the hospital.

Inspector #627 interviewed the DOC who confirmed that:

- the Fall Prevention and Management Program dated October 18, 2012, had not been updated or evaluated annually, and should have been.
- there was no education or training program related to falls for direct care staff.

- resident #016's care plan had not provided clear direction to the staff indicating how their assistive aid should have been applied, and should have.
- resident #016 should have had a head to toe assessment prior to being moved to a chair, and that had not occurred.
- RPN #110 had not reported the incident to the RN, NP, Physician or the family, and should have.
- RPN #110 and #114 had not completed the required head injury assessments and documentation as per the home's policy and should have.
- RPN #109, #114, #113 and RN #108 had not reported changes in condition immediately to the Physician or the NP, and should have. [s. 19. (1)]

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

Inspector # 620 reviewed a CI report submitted to the Director. The CI report alleged PSW#150 verbally and physically abused resident #021, and that it was witnessed by RPN #145, PSW #151, and #152.

The CI report described another incident of alleged verbal abuse involving PSW #150 that occurred on the same day. The second incident alleged that PSW #150 verbally abused resident #023. Food Service worker (FSW) #153 was reported to have witnessed the abuse.

A review of the home's investigation notes revealed that RPN #145, PSW #151, and #152, were witness to the physical and verbal abuse of resident #021 by PSW #150; however, neither of these staff members reported the incident of abuse until a week had passed. The second incident of verbal abuse that occurred on the same day was also not reported by FSW #153 until a week later.

The home's investigation revealed that PSW #150 was disciplined, and was required to review the home's Zero Tolerance of Abuse Policy.

A review of PSW #150's employee record revealed no indication that they had received education on the home's Zero Tolerance of Abuse Policy.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02 -01-04). The policy contained an effective date of July 2013. The policy also included the following statement from Ontario Regulation 99 LTCHA:

(a) that an analysis of every incident of abuse or neglect of a resident at the home is

undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The DOC confirmed that the policy was outdated and that there was no documented review or analysis of the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04) since July of 2013. The DOC stated that it was the homes expectation that an analysis and review of the policy should have been done annually; this did not occur and should have.

The DOC stated that they had no record to support that PSW #150 had received Zero Tolerance of Abuse Policy Training. The DOC could only confirm that PSW #150 had watched a video entitled, "One is One Too Many." The DOC stated that the video represented the entirety of the home's Zero Tolerance of Abuse Training, and that there was no staff training specific to the home's Zero Tolerance of Abuse Policy. The DOC stated that no records of staff training for Zero Tolerance of Abuse Policy had been documented by the home.

The decision to issue this compliance order was based on the severity which indicated actual harm or risk of harm and the scope was widespread, there was a compliance history with an immediate order having been issued on February 25, 2016. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately report the suspicions and the information upon which it was based to the Director.

Inspector #620 reviewed a CI report that was reported to the Director; the CI report alleged that PSW# 150 verbally and physically abused resident #021 and that the incident was witnessed by RPN #145, PSW #151, and #152.

The CI report describes another incident of alleged verbal abuse involving PSW #150

that occurred on the same day. The second incident alleged that PSW #150 verbally abused resident #023. FSW #153 was reported to have witnessed the abuse.

A review of the home's investigation notes revealed that RPN #145, PSW #151, and 152, were witness to the physical and verbal abuse of resident #021 by PSW #150; however, neither of these staff members reported the incident of abuse until a week later. The second incident of verbal abuse that occurred on the same day was also not reported by Food Services Worker #153 until a week had passed.

Inspector #620 interviewed the DOC who stated that RPN #145, PSW #151, 152, and Food Services Worker #153 witnessed PSW #150 verbally and physically abuse resident #023, and #021. The DOC confirmed that none of these staff members reported the incident until a week later. The DOC stated that it was the home's expectation that all incidences of suspected or witnessed abuse were to be reported immediately to the Director. The DOC stated that in the CI of verbal and physical abuse by PSW #150 toward resident #021 and #023, immediate notification to the Director had not occurred and should have. [s. 24. (1)]

2. On a certain date PSW #156 was supporting PSW #154 to assist resident #022. PSW #154 observed PSW #156 physically abuse resident #022. PSW #156 did not report the incident to the DOC until two days later. Therefore, the incident was not immediately reported to the Director after a direct care staff member became aware of the physical abuse.

Inspector #620 interviewed the DOC who stated that PSW #154, witnessed PSW #156 physically abuse resident #022. The DOC confirmed that PSW #154 did not report the incident until two days later. The DOC stated that it was the home's expectation that all incidences of suspected or witnessed abuse were to be reported immediately to the Director. The DOC stated that in the CI of physical abuse by PSW #156 toward resident #022, immediate notification to the Director had not occurred and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm and although the scope was isolated, there was a compliance history previously issued under the identical legislation with a compliance order having been issued on June 06, 2014, and a voluntary plan of correction on March 31, 2014. [s. 24. (1)]

Additional Required Actions:

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

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Inspector #620 and #627 conducted inspections related 21 Critical Incidents involving allegations of staff to resident abuse/neglect.

Inspector #620 interviewed the DOC who stated that there was no formal documented Zero Tolerance of Abuse training of all staff within the home. The DOC stated that the staff watched a video during orientation titled, "One is One Too Many." The DOC stated that they do not provide training on the home's Zero Tolerance of Abuse Policy annually with all staff. Staff in the home only received partial information related to the home's Zero Tolerance of Abuse Policy during staff meetings. The DOC confirmed that the staff meetings were not mandatory and the content of the meetings and who attended the meetings was not documented.

The DOC confirmed that they were aware of the requirement to provide training on the home's policy for Zero Tolerance of Abuse annually, and that the training had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm, the scope was widespread, there was a compliance history previously issued under the identical legislation with a voluntary plan of correction on June 25, 2013. [s. 76. (2) 3.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 and procedure instituted or otherwise put in place was complied with.

Inspector #627 conducted an inspection related to a CI report that was submitted to the Director. The critical incident described that resident #014 fell, was injured, and experienced a significant change in their health that required hospitalization.

A review of the home's policy on fall prevention and management titled, "Fall Assessment and Follow" dated November 12, 2012, revealed that after a fall Registered staff were expected to complete the "Fall Risk and Surveillance Assessment-2" document. The policy also directed registered staff to conduct an initial follow-up by completing a "Post Fall Note" every shift for 24 hours.

A review of the clinical record related to falls experienced by resident #014 for a six month period revealed that the on 11 occasions the Post Fall Note was not completed. Furthermore, on seven occasions the Surveillance Assessment-2 document had not been completed.

During an interview, the DOC stated that it was the home's expectation that registered staff would assess every resident who experiences a fall. The DOC stated that the assessment included the use of a Post Fall Note which was to be completed every shift for 24 hours; as well as, a Fall Risk and Surveillance Assessment-2 document for every fall. The DOC confirmed that both the Post Fall Note and the Surveillance Assessment-2 should have been completed for every fall experienced by resident #014 and that this had not occurred and should have. [s. 8. (1) (a),s. 8. (1) (b)]

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

Inspector #627 conducted an inspection related to a CI report that was submitted to the Director. The critical incident described that resident #013 fell and experienced a significant change in their health requiring hospitalization.

A review of the home's policy on fall prevention and management titled, "Fall Assessment and Follow" dated November 12, 2012, revealed that after a fall Registered staff were expected to complete the "Fall Risk and Surveillance Assessment-2" document. The policy also directed registered staff to conduct an initial follow-up by completing a, "Post Fall Note" every shift for 24 hours. Registered staff were also expected to document a, "Fall Risk Assessment."

A review of resident #013's clinical record related to falls for a four month period revealed that on ten occasions no Post Fall Note was documented as was required. On two occasions no Fall Risk and Surveillance Assessment-2 was documented as was required. On three occasions the Fall Risk Assessment was only partially completed.

During an interview, the DOC confirmed that it was the home's expectation that a Post Fall Note, Fall Risk Assessment, and Surveillance Assessment-2 should have been completed for every fall experienced by a resident. The DOC stated that with respect to resident #013's falls, this had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated actual harm or risk of harm, the scope was widespread, there was a compliance history previously issued under the identical legislation with a voluntary plan of correction on April 07, 2015. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

On February 23, 2016, Inspector #627 attended to a specific unit of the home. While on the unit the Inspector observed that there was only one resident on the unit. The inspector attempted to locate a staff member on the unit; however, Inspector #627 discovered that there were no staff members on the unit. Inspector # 627 initiated the resident's call bell.

The call bell illuminated a light in the hallway and an auditory tone could be heard. The call bell went unanswered for more than 30 minutes. Inspector #627 sought the assistance of Inspector #620.

Inspector #620 sought the assistance of the DOC. The DOC and Inspector #620

surveyed the unit and both confirmed that the unit was devoid of any staff members, leaving a resident unattended on the specific unit. The DOC stated that it was the home's expectation that residents were not to be left unattended. The DOC stated that the staff members from the unit had likely gone to the unit on another floor to assist with the breakfast meal. The DOC confirmed that having an unattended resident on the specific unit presented a safety risk to the resident and that it should not have occurred.

Following the incident, the DOC conducted an investigation to determine the cause of the unattended unit. The DOC concluded that staff member #190, who was normally assigned to remain on the unit when other staff left to assist with meals, had called in sick that day and had not been replaced. The DOC stated that the staff that left the unit to assist with meal service elsewhere had been unaware that staff member #190 was not working on the unit; therefore, they left the unit believing staff member #190 was there to attend to the resident.

Inspector #620 interviewed the DOC who stated that there was no written staffing plan that included a back-up plan for nursing and personal care services. The DOC stated that they were unaware that a written back-up plan was required. The DOC stated that when a staff member called in, they would make a decision on whether to call in a replacement staff member; however, there was no document that detailed what informed The DOC to make their decision.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm, the scope was widespread, and there was a history of previously unrelated non-compliance. [s. 31. (3) (d)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 received discipline.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 was disciplined.

Inspector #620 interviewed the DOC who stated that with respect to the allegation of physical abuse by PSW #112 toward resident #015, the allegation was substantiated. The DOC further stated that it was the home's expectation that residents were to be protected from abuse by staff and that in this CI, resident #015 was physically abused by PSW #112, and should not have been.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02 -01-04). The policy contained an effective date of July 2013. The policy also included the following statement from Ontario Regulation 99 LTCHA:

a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The DOC confirmed that the policy was outdated and that there was no documented review or analysis of the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04) since July of 2013. The DOC stated that it was the homes expectation that an analysis and review of the policy should have been done annually; this did not occur and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm, the scope was widespread, and there was a history of previously identical non-compliance, with a written notice having been issued to the home on June 25, 2013. [s. 99. (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that that direct care staff were provided with training in falls prevention and management.

Inspector #627 inspected three critical incident reports related to resident falls that were submitted to the Director.

A document review by Inspector #627 revealed that there were no training records related to falls that indicated that direct care staff had received falls prevention training.

During an interview, the DOC confirmed that the home had not provided direct care staff with training specific to falls prevention management, and should have.

The decision to issue this compliance order was based on the severity which indicated actual harm or risk of harm, the scope was widespread, there was a compliance history with one written notice having been issued on January 20, 2014. [s. 221. (1) 1.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the Fall Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #627 reviewed the home's Fall Prevention and Management Program. The review revealed that the Program had last received an evaluation in 2012.

During an interview, the DOC confirmed that it was the home's expectation that the Fall Prevention and Management Program was to be evaluated annually in accordance with the LTCH Act. The DOC confirmed that the Fall Prevention and Management Program had not been evaluated annually and should have been. [s. 30. (1) 3.]

2. The Licensee failed to ensure that the Continence care and Bowel Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #627 reviewed the Continence Care and Bowel Management Program (CR 12-02-01). The Continence Care and Bowel Management Program's most recent evaluation had occurred in August 2013.

During an interview, the DOC confirmed that it was the home's expectation that the Continence Care and Bowel Management Program was to be evaluated annually in accordance with the LTCH Act. The DOC confirmed that the Continence care and Bowel Management Program had not been evaluated annually, and should have been.

The decision to issue this compliance order was based on the severity which indicated minimum risk, the scope was widespread, and there was a history of previously identical non-compliance, with a voluntary plan of correction having been issued to the home on April 07, 2015. [s. 30. (1) 3.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Inspector #627 conducted an inspection related to a CI report that was submitted to the Director. The critical incident described that resident #013 fell, and experienced a significant change in their health condition requiring hospitalization.

A review of the care plan revealed that the level of care indicated within the care plan was often contradictory. A review of the Kardex for resident #013 exposed further contradiction within the plan of care.

During an interview, PSW #136 stated that resident #013 required a specific level of assistance. The PSW also stated that the plan of care offered staff contradictory instruction on how to care for resident #013.

Upon reviewing the care plan and the kardex, the RPN #137 confirmed the plan of care failed to provide clear direction to staff, and should have. [s. 6. (1) (c)]

2. The home submitted CI report to the Director which indicated that resident #016

had a fall which resulted in a significant change to their health condition and required the resident to be admitted to the hospital.

The investigation notes contained a typed statement from PSW #146 stating they were told by a staff member that resident #016 required a specific assistive device. The assistive device had been incorrectly utilized and resulted in the resident's fall.

A review of the resident #016's plan of care revealed an absence of any direction identifying how the assistive device was to be utilized.

During an interview, the DOC confirmed that the care plan had not provided clear direction to staff indicating how the assistive device was to be utilized, and should have. [s. 6. (1) (c)]

3. A CI report was submitted to the Director. The report alleged that resident #011 was incontinent in bed. The report stated that resident #011's family member reported to the DOC in an email that they had arrived and found the resident incontinent in bed.

An investigation completed by the home identified that resident #011 often refused care when incontinent.

A review of the progress notes for the six months that preceded the incident revealed resident #011 refused care frequently.

A review of the care plan in effect at the time of the incidence, revealed that there was no focus, goals, or interventions to address the resident's refusal of care.

During an interview, the DOC stated that if a resident refused care on a continuous basis, the behavior should have been addressed in the care plan. The DOC confirmed that the care plan for resident #011 had not addressed the resident's frequent refusal of care, and did not provide clear direction to staff for managing resident #011's refusal of care, and should have. [s. 6. (1) (c)]

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

Inspector #627 reviewed a CI reported to the Director. The CI report alleged that PSW #120 did not provide resident #010 with their specific toileting device, and told the resident to void in their brief. The report also alleged that the PSW hid the specific

toileting device from other staff.

A review of the home's investigation documents indicated that PSW #120 did not the resident with the specific toileting device. Instead they provided an alternate toileting device because PSW #120 believed that this ensured that resident #110 would not be incontinent; thereby, preserving the resident's dignity.

The care plan in effect at the time of the incident, dated December 4, 2014, had the following intervention under the focus of toileting:
-Resident uses a specific toileting device throughout the day and will request it at night as well.

During an interview, the DOC confirmed that it was the home's expectation that residents were to receive care as specified in the plan of care. The DOC stated that resident #110 had not been provided a specific toileting device as specified in the plan of care; therefore, care was not provided as specified in the plan, and should have been. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the plan of care sets out clear direction to staff and others who provide direct care to residents, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspected may have constituted a criminal offence.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 received discipline.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 was disciplined.

Inspector #620 interviewed the DOC on February 16, 2016. The DOC stated that with respect to the allegation of physical abuse by PSW #112 toward resident #015, the allegation was substantiated. The DOC further stated that it was the home's expectation that residents were to be protected from abuse by staff and that in this CI, resident #015 was physically abused by PSW #112, and should not have been.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02 -01-04). The policy stated that the home would ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

The policy also advised staff to complete document, "VII-G-10.00(B) Reporting and Investigating Alleged Abuse Checklist". One of the checklist items advised staff to, "Notify Police services (911) for occurrences of assault or willful infliction of physical pain or injury, sexual assault, alleged fraud/theft if directed by the CEO.

In an interview with Inspector #620 on February 16, 2016, the DOC confirmed that they determined the physical abuse of resident #015 by PSW #112 to be an assault reportable to the police; however, the police were not contacted because the police were only to be called when it was authorized by the CEO. They stated that the CEO would not authorize them to notify the police.

Inspector #620 interviewed the CEO on February 16, 2016. The CEO stated that all notifications to police, stemming from incidents occurring in the home, were to be authorized by them. The CEO stated that in the incident of physical abuse by PSW

#112 toward resident #015 the police were not contacted because they considered it to be a waste of tax dollars. They further noted that all incidents of financial abuse were reported to the police; however, physical abuse is reported only if the incident results in serious injury. [s. 98.]

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 ensuring that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may have constituted a criminal offence., to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home at least 35 hours per week.

Inspector #620 conducted an inspection in the home from February 16-19, 2016, and February 22-26, 2016. During the course of inspection, Inspector #620 observed that the Administrator was often absent from the home.

Inspector #620 observed that from February 16-19, 2016, the Administrator was on site less than 20 hours. From February 22-26, 2016, the Administrator was also on site less than 20 hours.

Inspector #620 interviewed three of the home's staff members who all confirmed that the Administrator most often arrived at the home between 1200 hours and 1300 hours and usually left the home at 1630 hours.

Inspector #620 interviewed the Administrator who denied being off-site because of meetings or training related to operation of the home. The Administrator stated that they usually arrived at the home by 1100 hours but worked from home on some days. The Administrator stated that they were not required to be on site because they were available either by telephone or email. The Administrator stated that the home did not require their body but rather their intellectual capacity. The Administrator stated that they had no intent of altering their current hours and that this particular portion of the legislation was "stupid." [s. 212. (1) 3.]

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 ensuring that the home's Administrator works regularly in their position on site at the home at least 35 hours per week, to be implemented voluntarily.

Issued on this 29 day of April 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

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TORONTO, ON, M2M-4K5
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALAIN PLANTE (620) - (A1)

Inspection No. / No de l'inspection : 2016_336620_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 003306-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Apr 29, 2016;(A1)

Licensee / Titulaire de permis :
IOOF SENIORS HOMES INC.
20 Brooks Street, BARRIE, ON, L4N-5L3

LTC Home / Foyer de SLD :
ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Doreen Saunders

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To IOOF SENIORS HOMES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents are protected from abuse by anyone and are not neglected by staff.

Grounds / Motifs :

1. The licensee failed to ensure that residents were not neglected by the license or staff.

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

The home submitted critical incident report to the Director. The CI report indicated that resident #016 had a fall which resulted in a significant change and required the resident to be admitted to the hospital.

A review of the homes investigation notes revealed that resident #016 sustained a fall and was injured.

The investigation notes also contained a typed statement from PSW #146 stating they were told by a staff member that resident #016 had used an assistive aid. A review of the resident #016's plan of care revealed an absence of any direction

identifying how the resident's assistive aid was to be utilized.

Inspector #627 reviewed the home's policy titled, "Fall Prevention and Management-Fall Assessment and Follow-up." The Policy was out of date and had not been evaluated/updated since October 18, 2012.

The policy stated that registered staff were not to mobilize the resident, until a full head to toe assessment had been completed. The policy also advised staff to notify family/POA and Physician and/or NP of the fall.

A review of policy "#RC12-00-03- Head Injury Routine" revealed that following a known or potential head injury RN/RPN staff were expected to notify the Physician and/or Nurse Practitioner (NP) of the resident's current condition and any time resident's condition changed. Notify the resident's family/Power of Attorney for Personal Care immediately of the incident and condition of the resident.

The home's policy also required staff to document head injury assessments using form #RC-12-00-03-01 (Head Injury Assessment Record). The assessment form was intended to document the resident's blood pressure (BP), pulse, respirations, level of consciousness, orientation, limb movement, and pupillary response every 15 minutes for the first hour, then every 30 minutes for the next two hours, then every hour for the next four hours, then every four hours for the next 48 hours.

A review of the head injury assessment record for resident #016 revealed that the initial entry on the document was not completed in full. The record also showed that resident #016 was not assessed, as required, on five occasions within the first 30 hours following their injury.

Inspector #627 interviewed RPN #110 who stated they were the first to attend to resident #016 following their fall. RPN #110 stated that they called another RPN for assistance. Resident #016 was assisted and moved to a chair before a head to toe assessment was conducted. RPN #110 stated that another RPN completed the head to toe post fall assessment while the resident was sitting in a chair. The resident was then taken to their room and a head injury protocol was initiated. RPN #110 stated they did not complete all the required head injury assessments because the resident was sleeping. RPN #110 stated that they did not notify the RN, the NP or a Physician, of the injury, and did not notify the family of the fall.

Inspector #627 interviewed RPN #113, who cared for resident #016 during an evening shift. RPN #113 stated they felt the resident was oriented to person as they recognized that they were a staff member. RPN #113 stated that when they asked what time of the day and where they were, they incorrectly answered. RPN #113 stated they were told by another staff member that the resident had vomited. RPN #113 stated they did not call an RN, the NP or the Physician to report the vomiting or the confusion.

RPN #109, who cared for resident #016 during the night shift, stated they called RN #108 to report that the resident's increased blood pressure and that the resident had two episode of emesis. The RPN was told by the RN to monitor the resident.

During an interview, RN #108 stated that they were called to assess resident #016. It was reported to them that the resident's health condition had deteriorated. RN #108 stated they did not notify the NP or Physician of the elevated blood pressure or the continued emesis. They advised the RPN to monitor the resident.

RPN #107, who cared for resident #016 during the day shift, stated they were not told during report that resident #016 was on a head injury protocol during report; therefore, the resident had not been assessed as required. When RPN #107 learned of the head injury they assessed resident #016. They found the resident to be exhibiting acute signs of adverse health. RPN #107 called Emergency Medical Services, who arrived and transported resident #016 to the hospital.

Inspector #627 interviewed the DOC who confirmed that:

- the Fall Prevention and Management Program dated October 18, 2012, had not been updated or evaluated annually, and should have been.
- there was no education or training program related to falls for direct care staff.
- resident #016's care plan had not provided clear direction to the staff indicating how their assistive aid should have been applied, and should have.
- resident #016 should have had a head to toe assessment prior to being moved to a chair, and that had not occurred.
- RPN #110 had not reported the incident to the RN, NP, Physician or the family, and should have.
- RPN #110 and #114 had not completed the required head injury assessments and documentation as per the home's policy and should have.
- RPN #109, #114, #113 and RN #108 had not reported changes in condition

immediately to the Physician or the NP, and should have. [s. 19. (1)] (620)

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

The home submitted a Critical Incident (CI) report to the Director that alleged PSW#112 physically abuse resident #015 which resulted in an injury to the resident. According to the report the resident PSW #112 also scolded them.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 received discipline.

Inspector #620 interviewed the DOC on February 16, 2016. The DOC stated that with respect to the allegation of physical abuse by PSW #112 toward resident #015, the allegation was substantiated. The DOC further stated that it was the home's expectation that residents were to be protected from abuse by staff and that in this CI, resident #015 was physically abused by PSW #112, and should not have been.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04). The policy contained an effective date of July 2013. The policy also included the following statement from Ontario Regulation 99 of the LTCHA:

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The policy further stated that the home would ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may have constituted a criminal offence.

The DOC confirmed that the policy was outdated and that there was no documented review or analysis of the home's Zero Tolerance for Abuse and Neglect Policy (02-01 -04) since July of 2013. The DOC stated that it was the homes expectation that an analysis and review of the policy should have been done annually; this did not occur and should have.

Inspector #620 further reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04). The policy stated that the home would ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may have constituted a criminal offence.

The policy also advised staff to complete document, "VII-G-10.00(B) Reporting and Investigating Alleged Abuse Checklist". One of the checklist items advised staff to, "Notify Police services (911) for occurrences of assault or willful infliction of physical pain or injury, sexual assault, alleged fraud/theft if directed by the CEO.

In an interview with Inspector #620 on February 16, 2016, the DOC confirmed that they determined the physical abuse of resident #015 by PSW #112 to be an assault reportable to the police; however, the police were not contacted because the police were only to be called when it was authorized by the CEO. They stated that the CEO would not authorize them to notify the police.

Inspector #620 interviewed the CEO on February 16, 2016. The CEO stated that all notifications to police, stemming from incidents occurring in the home, were to be authorized by them. The CEO stated that in the incident of physical abuse by PSW #112 toward resident #015 the police were not contacted because they considered it to be a waste of tax dollars. They further noted that all incidents of financial abuse

are reported to the police; however, physical abuse is reported only if the incident results in serious injury. [s. 19. (1)]
(627)

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

Inspector # 620 reviewed a CI report submitted to the Director. The CI report alleged PSW#150 verbally and physically abused resident #021, and that it was witnessed by RPN #145, PSW #151, and #152.

The CI report described another incident of alleged verbal abuse involving PSW #150 that occurred on the same day. The second incident alleged that PSW #150 verbally abused resident #023. Food Service worker (FSW) #153 was reported to have witnessed the abuse.

A review of the home's investigation notes revealed that RPN #145, PSW #151, and #152, were witness to the physical and verbal abuse of resident #021 by PSW #150; however, neither of these staff members reported the incident of abuse until a week had passed. The second incident of verbal abuse that occurred on the same day was also not reported by FSW #153 until a week later.

The home's investigation revealed that PSW #150 was disciplined, and was required to review the home's Zero Tolerance of Abuse Policy.

A review of PSW #150's employee record revealed no indication that they had received education on the home's Zero Tolerance of Abuse Policy.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04). The policy contained an effective date of July 2013. The policy also included the following statement from Ontario Regulation 99 LTCHA:

(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero

tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The DOC confirmed that the policy was outdated and that there was no documented review or analysis of the home's Zero Tolerance for Abuse and Neglect Policy (02-01 -04) since July of 2013. The DOC stated that it was the homes expectation that an analysis and review of the policy should have been done annually; this did not occur and should have.

The DOC stated that they had no record to support that PSW #150 had received Zero Tolerance of Abuse Policy Training. The DOC could only confirm that PSW #150 had watched a video entitled, "One is One Too Many." The DOC stated that the video represented the entirety of the home's Zero Tolerance of Abuse Training, and that there was no staff training specific to the home's Zero Tolerance of Abuse Policy. The DOC stated that no records of staff training for Zero Tolerance of Abuse Policy had been documented by the home.

The decision to issue this compliance order was based on the severity which indicated actual harm or risk of harm and the scope was widespread, there was a compliance history with an immediate order having been issued on February 25, 2016. [s. 19. (1)] (620)

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

May 10, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a 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 this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is to immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately report the suspicions and the information upon which it was based to the Director.

Inspector #620 reviewed a CI report that was reported to the Director; the CI report alleged that PSW# 150 verbally and physically abused resident #021 and that the incident was witnessed by RPN #145, PSW #151, and #152.

The CI report describes another incident of alleged verbal abuse involving PSW #150 that occurred on the same day. The second incident alleged that PSW #150 verbally abused resident #023. FSW #153 was reported to have witnessed the abuse.

A review of the home's investigation notes revealed that RPN #145, PSW #151, and 152, were witness to the physical and verbal abuse of resident #021 by PSW #150; however, neither of these staff members reported the incident of abuse until a week later. The second incident of verbal abuse that occurred on the same day was also not reported by Food Services Worker #153 until a week had passed.

Inspector #620 interviewed the DOC who stated that RPN #145, PSW #151, 152, and Food Services Worker #153 witnessed PSW #150 verbally and physically abuse resident #023, and #021. The DOC confirmed that none of these staff members reported the incident until a week later. The DOC stated that it was the home's expectation that all incidences of suspected or witnessed abuse were to be reported immediately to the Director. The DOC stated that in the CI of verbal and physical abuse by PSW #150 toward resident #021 and #023, immediate notification to the Director had not occurred and should have. [s. 24. (1)] (620)

2. On a certain date PSW #156 was supporting PSW #154 to assist resident #022. PSW #154 observed PSW #156 physically abuse resident #022. PSW #156 did not report the incident to the DOC until two days later. Therefore, the incident was not immediately reported to the Director after a direct care staff member became aware of the physical abuse.

Inspector #620 interviewed the DOC who stated that PSW #154, witnessed PSW #156 physically abuse resident #022. The DOC confirmed that PSW #154 did not report the incident until two days later. The DOC stated that it was the home's expectation that all incidences of suspected or witnessed abuse were to be reported immediately to the Director. The DOC stated that in the CI of physical abuse by PSW #156 toward resident #022, immediate notification to the Director had not occurred and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm and although the scope was isolated, there was a compliance history previously issued under the identical legislation with a compliance order having been issued on June 06, 2014, and a voluntary plan of correction on March 31, 2014. [s. 24. (1)]
(620)

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

May 10, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall,

1.) develop training materials specific to the home's policy to promote zero tolerance of abuse and neglect;

2.) ensure that all staff are trained on the home's policy to promote zero tolerance of abuse and neglect of residents including:

a.) how to recognize neglect and the different types of abuse,

b.) the requirement for mandatory reporting of abuse,

c.) how and when the reporting is to occur, and

d.) when a report is required to be made to the police.

3.) develop and implement a process for ensuring that the training materials are effective; and

4.) ensure that a record is kept that identifies who received training and when that training occurred.

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

Grounds / Motifs :

1. The licensee failed to ensure that all staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Inspector #620 and #627 conducted inspections related 21 Critical Incidents involving allegations of staff to resident abuse/neglect.

Inspector #620 interviewed the DOC who stated that there was no formal documented Zero Tolerance of Abuse training of all staff within the home. The DOC stated that the staff watched a video during orientation titled, "One is One Too Many." The DOC stated that they do not provide training on the home's Zero Tolerance of Abuse Policy annually with all staff. Staff in the home only received partial information related to the home's Zero Tolerance of Abuse Policy during staff meetings. The DOC confirmed that the staff meetings were not mandatory and the content of the meetings and who attended the meetings was not documented.

The DOC confirmed that they were aware of the requirement to provide training on the home's policy for Zero Tolerance of Abuse annually, and that the training had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm, the scope was widespread, there was a compliance history previously issued under the identical legislation with a voluntary plan of correction on June 25, 2013. [s. 76. (2) 3.] (620)

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

May 20, 2016

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall,

1.) develop and implement a system to audit and analyze how the home's direct care staff respond to resident falls.

a.) ensure that the system maintains a record of when staff fail to adhere to the home's Program for Falls Prevention and Management.

Grounds / Motifs :

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

Inspector #627 conducted an inspection related to a CI report that was submitted to the Director. The critical incident described that resident #014 fell, was injured, and experienced a significant change in their health that required hospitalization.

A review of the home's policy on fall prevention and management titled, "Fall Assessment and Follow" dated November 12, 2012, revealed that after a fall Registered staff were expected to complete the "Fall Risk and Surveillance Assessment-2" document. The policy also directed registered staff to conduct an initial follow-up by completing a "Post Fall Note" every shift for 24 hours.

A review of the clinical record related to falls experienced by resident #014 for a six month period revealed that the on 11 occasions the Post Fall Note was not completed. Furthermore, on seven occasions the Surveillance Assessment-2 document had not been completed.

During an interview, the DOC stated that it was the home's expectation that registered staff would assess every resident who experiences a fall. The DOC stated that the assessment included the use of a Post Fall Note which was to be completed every shift for 24 hours; as well as, a Fall Risk and Surveillance Assessment-2 document for every fall. The DOC confirmed that both the Post Fall Note and the Surveillance Assessment-2 should have been completed for every fall experienced by resident #014 and that this had not occurred and should have. [s. 8. (1) (a),s. 8. (1) (b)] (627)

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

Inspector #627 conducted an inspection related to a CI report that was submitted to the Director. The critical incident described that resident #013 fell and experienced a significant change in their health requiring hospitalization.

A review of the home's policy on fall prevention and management titled, "Fall Assessment and Follow" dated November 12, 2012, revealed that after a fall Registered staff were expected to complete the "Fall Risk and Surveillance Assessment-2" document. The policy also directed registered staff to conduct an initial follow-up by completing a, "Post Fall Note" every shift for 24 hours. Registered staff were also expected to document a, "Fall Risk Assessment."

A review of resident #013's clinical record related to falls for a four month period revealed that on ten occasions no Post Fall Note was documented as was required. On two occasions no Fall Risk and Surveillance Assessment-2 was documented as was required. On three occasions the Fall Risk Assessment was only partially completed.

During an interview, the DOC confirmed that it was the home's expectation that a Post Fall Note, Fall Risk Assessment, and Surveillance Assessment-2 should have been completed for every fall experienced by a resident. The DOC stated that with respect to resident #013's falls, this had not occurred, and should have.

The decision to issue this compliance order was based on the severity which indicated actual harm or risk of harm, the scope was widespread, there was a compliance history previously issued under the identical legislation with a voluntary plan of correction on April 07, 2015. [s. 8. (1) (a),s. 8. (1) (b)] (627)

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

May 20, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

(b) set out the organization and scheduling of staff shifts;

(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and

(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall,

1.) develop and implement a written staffing plan; ensure the staffing plan:

a.) provides a staffing mix that is consistent with residents' care and safety needs,

b.) sets out the organization of scheduling and shifts,

c.) promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,

d.) includes a written back-up plan for nursing and personal care staffing that addresses situations when staff who must provide the nursing coverage cannot come to work, and

e.) identifies how and when staff are required to institute the back-up plan for nursing and personal care staffing;

2.) provide training to all staff identified to have responsibility for instituting the home's back-up plan for nursing and personal care staffing, and maintain a record of who was trained, and when it occurred; and

3.) ensure that an annual evaluation is conducted hereafter following the development and implementation the staffing plan, and maintain a record of the evaluation.

Grounds / Motifs :

1. The licensee failed to ensure that there was a written staffing plan that included a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide nursing coverage required under subsection 8 (3) of the Act, cannot come to work.

On February 23, 2016, Inspector #627 attended to a specific unit of the home. While on the unit the Inspector observed that there was only one resident on the unit. The inspector attempted to locate a staff member on the unit; however, Inspector #627

discovered that there were no staff members on the unit. Inspector # 627 initiated the resident's call bell.

The call bell illuminated a light in the hallway and an auditory tone could be heard. The call bell went unanswered for more than 30 minutes. Inspector #627 sought the assistance of Inspector #620.

Inspector #620 sought the assistance of the DOC. The DOC and Inspector #620 surveyed the unit and both confirmed that the unit was devoid of any staff members, leaving a resident unattended on the specific unit. The DOC stated that it was the home's expectation that residents were not to be left unattended. The DOC stated that the staff members from the unit had likely gone to the unit on another floor to assist with the breakfast meal. The DOC confirmed that having an unattended resident on the specific unit presented a safety risk to the resident and that it should not have occurred.

Following the incident, the DOC conducted an investigation to determine the cause of the unattended unit. The DOC concluded that staff member #190, who was normally assigned to remain on the unit when other staff left to assist with meals, had called in sick that day and had not been replaced. The DOC stated that the staff that left the unit to assist with meal service elsewhere had been unaware that staff member #190 was not working on the unit; therefore, they left the unit believing staff member #190 was there to attend to the resident.

Inspector #620 interviewed the DOC who stated that there was no written staffing plan that included a back-up plan for nursing and personal care services. The DOC stated that they were unaware that a written back-up plan was required. The DOC stated that when a staff member called in, they would make a decision on whether to call in a replacement staff member; however, there was no document that detailed what informed The DOC to make their decision.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm, the scope was widespread, and there was a history of previously unrelated non-compliance. [s. 31. (3) (d)] (620)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

May 20, 2016

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 99. Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Order / Ordre :

The licensee shall,

1.) ensure that an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

a.) ensure that the changes and improvements to the policy as required in the evaluation are promptly implemented;

2.) ensure that a written record of everything provided for in (a) and (b) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared; and

3.) ensure that the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect is evaluated at least once in every calendar year thereafter.

Grounds / Motifs :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 received discipline.

A review of the home's investigation notes revealed that PSW #112 was determined to have physically abused and injured resident #015. As a result of the home's investigation PSW #112 was disciplined.

Inspector #620 interviewed the DOC who stated that with respect to the allegation of physical abuse by PSW #112 toward resident #015, the allegation was substantiated. The DOC further stated that it was the home's expectation that residents were to be protected from abuse by staff and that in this CI, resident #015 was physically

abused by PSW #112, and should not have been.

Inspector #620 reviewed the home's Zero Tolerance for Abuse and Neglect Policy (02-01-04). The policy contained an effective date of July 2013. The policy also included the following statement from Ontario Regulation 99 LTCHA:

a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes and improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

The DOC confirmed that the policy was outdated and that there was no documented review or analysis of the home's Zero Tolerance for Abuse and Neglect Policy (02-01 -04) since July of 2013. The DOC stated that it was the homes expectation that an analysis and review of the policy should have been done annually; this did not occur and should have.

The decision to issue this compliance order was based on the severity which indicated potential risk for actual harm, the scope was widespread, and there was a history of previously identical non-compliance, with a written notice having been issued to the home on June 25, 2013. [s. 99. (b)] (620)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

May 20, 2016

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

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

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall,

1.) develop training materials for the home's program for falls prevention and management; and

2.) ensure all direct care staff are trained on the home's program for falls prevention and management, and maintain a record of who received the training, and the date that it occurred.

Grounds / Motifs :

1. The licensee failed to ensure that that direct care staff were provided with training in falls prevention and management.

Inspector #627 inspected three critical incident reports related to resident falls that were submitted to the Director.

A document review by Inspector #627 revealed that there were no training records related to falls that indicated that direct care staff had received falls prevention training.

During an interview, the DOC confirmed that the home had not provided direct care staff with training specific to falls prevention management, and should have.

The decision to issue this compliance order was based on the severity which indicated actual harm or risk of harm, the scope was widespread, there was a compliance history with one written notice having been issued on January 20, 2014. [s. 221. (1) 1.] (627)

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

May 20, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Order / Ordre :

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

The licensee shall,

1.) conduct an audit and analysis of the falls that have occurred in the home for one calendar year previous to the issuance of this order;

2.) conduct an evaluation and revision of the home’s Falls Prevention and Management Program, ensuring that it complies with Ontario Regulation 79/10, s. 49; and

3.) conduct an evaluation and revision of the home’s Continence Care and Bowel Management Program, ensuring that it complies with Ontario Regulation 79/10, s. 51 (1).

Grounds / Motifs :

1. The Licensee failed to ensure that the Fall Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #627 reviewed the home's Fall Prevention and Management Program. The review revealed that the Program had last received an evaluation in 2012.

During an interview, the DOC confirmed that it was the home's expectation that the Fall Prevention and Management Program was to be evaluated annually in accordance with the LTCH Act. The DOC confirmed that the Fall Prevention and Management Program had not been evaluated annually and should have been. [s. 30. (1) 3.] (627)

2. The Licensee failed to ensure that the Continence care and Bowel Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #627 reviewed the Continence Care and Bowel Management Program (CR 12-02-01). The Continence Care and Bowel Management Program's most recent evaluation had occurred in August 2013.

During an interview, the DOC confirmed that it was the home's expectation that the Continence Care and Bowel Management Program was to be evaluated annually in accordance with the LTCH Act. The DOC confirmed that the Continence care and Bowel Management Program had not been evaluated annually, and should have been.

The decision to issue this compliance order was based on the severity which indicated minimum risk, the scope was widespread, and there was a history of previously identical non-compliance, with a voluntary plan of correction having been issued to the home on April 07, 2015. [s. 30. (1) 3.] (627)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

May 20, 2016

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions 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

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

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Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29 day of April 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ALAIN PLANTE - (A1)

Service Area Office /
Bureau régional de services : Toronto