Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_661683_0008	003925-17, 008038-17, 008725-17, 011357-17, 013258-17, 014120-17, 016521-17, 024086-17, 004650-18, 005262-18, 019549-18, 021925-18, 029083-18, 029084-18, 029085-18, 029088-18, 029089-18, 030798-18, 030799-18, 030801-18, 000980-19, 004001-19, 007426-19, 008278-19, 008611-19, 008843-19	Critical Incident System

Licensee/Titulaire de permis

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

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

LISA BOS (683), AILEEN GRABA (682), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), STACEY GUTHRIE (750)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 23, 24, 25, 26, 29, May 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22 and 23, 2019.

This inspection was completed concurrently with complaint inspection #2019_661683_0007 and follow up inspection #2019_661683_0009.

The following intakes were completed during this critical incident inspection:
Log #003925-17, CIS #2931-000001-17 - related to the prevention of abuse and neglect and continence care and bowel management
Log #008038-17, CIS #2931-000008-17 - related to the prevention of abuse and neglect
Log #008725-17, CIS #2931-000009-17 - related to the prevention of abuse and neglect
Log #011357-17, CIS #2931-000013-17 - related to the prevention of abuse and neglect
Log #013258-17, CIS #2931-000015-17 - related to the prevention of abuse and neglect
Log #014120-17, CIS #2931-000018-17 - related to critical incident reporting
Log #016521-17, CIS #2931-000019-17 - related to the prevention of abuse and neglect
Log #024086-17, CIS #2931-000029-17 - related to the prevention of abuse and neglect
Log #004650-18, CIS #2931-000006-18 - related to the prevention of abuse and neglect
Log #005262-18, CIS #2931-000007-18 - related to the prevention of abuse and neglect
Log #019549-18, CIS #2931-000022-18 - related to the prevention of abuse and neglect

Log #021925-18, CIS #2931-000026-18 - related to the prevention of abuse and neglect
Log #000980-19, CIS #2931-000003-19 - related to the prevention of abuse and neglect
Log #004001-19, CIS #2931-000008-19 - related to falls prevention and management
Log #007426-19, CIS #2931-000012-19 - related to medication administration
Log #008278-19, CIS #2931-000013-19 - related to falls prevention and management
Log #008611-19, CIS #2931-000014-19 - related to the prevention of abuse and neglect and responsive behaviours
Log #008843-19, CIS #2931-000016-19 - related to falls prevention and management

The following follow-up inspections were completed concurrently with this critical incident inspection:

Log #029083-18 - related to CO #001 from inspection #2018_743536_0006 regarding LTCHA, 2007 s. 19 (1)
Log #029084-18 - related to CO #002 from inspection #2018_743536_0006 regarding LTCHA, 2007 s. 23 (1)
Log #029085-18 - related to CO #003 from inspection #2018_743536_0006 regarding LTCHA, 2007 s. s. 76
Log #029088-18 - related to CO #004 from inspection #2018_743536_0006 regarding O. Reg. 79/10 s. 54
Log #029089-18 - related to CO #005 from inspection #2018_743536_0006 regarding O. Reg. 79/10 s. 98
Log #030801-18 - related to CO #002 from inspection #2018_695156_0007 regarding O. Reg. 79/10 s. 221 (1)
Log #030799-18 - related to CO #003 from inspection #2018_695156_0007 regarding O. Reg. 79/10 s. 8 (1)
Log #030798-18 - related to CO #004 from inspection #2018_695156_0007 regarding LTCHA, 2007 s. 6 (7)

PLEASE NOTE:
A Written Notification (WN) and Compliance Order (CO) related to LTCHA, 2007, c.8, s. 6 (7) and s. 76, identified in a concurrent inspection #2019_661683_0007 were issued in this report.
A WN and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 6 (11) (b) identified in concurrent inspection #2019_661683_0007 (log #029655-18) was issued in this report.

A WN related to O. Reg. 79/10, s. 101 (1) 3, identified in concurrent inspection #2019_661683_0007 (log #020837-18) was issued in this report.
A WN and VPC related to O. Reg. 79/10 s. 131 (1) and a WN, CO and Director Referral (DR) related to O. Reg. 79/10 s. 131 (2) were identified in this inspection and have been issued in Inspection Report #2019_661683_0009, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director(s) of Nursing (DON), the Manager of Food Services, the Assistant Food Service Manager, the Manager of Recreation and Volunteer Services, the Manager of Facilities, the Registered Dietitian (RD), the Resident Assessment Instrument (RAI) Coordinator, the Nursing Administrative Assistant, the Nurse Practitioner (NP), the Physiotherapist (PT), registered staff, Personal Support Workers (PSW), recreation staff, residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed the complaints log, reviewed meeting minutes, reviewed program evaluation records, reviewed staffing records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Reporting and Complaints
Responsive Behaviours

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

21 WN(s)
12 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 221. (1)	CO #002	2018_695156_0007	583
O.Reg 79/10 s. 54.	CO #004	2018_743536_0006	583
O.Reg 79/10 s. 98.	CO #005	2018_743536_0006	682

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to identified fall prevention interventions.

A) A review of the written plan of care for resident #043 identified that they were at risk for falls and had various interventions in place to try and prevent falls.

i) At an identified time, on an identified date, an observation was made of resident #043. At an identified time, Inspector #683 and the Administrator observed the resident's room and an identified fall prevention intervention was noted to be in place, but not connected correctly. At an identified time PSW #126 confirmed, in the presence of the Administrator, that the identified fall prevention intervention was not in working order since it was not connected correctly.

The home did not ensure that the identified fall prevention intervention for resident #043 was connected correctly and in working order on an identified date, as identified in their written plan of care. (683)

ii) A review of the clinical record for resident #043 identified progress notes from an identified date, which indicated that a specific fall prevention intervention was not in place.

In an interview with PSW #126 on an identified date, they indicated a specific reason as to why resident #043 did not have their identified fall prevention intervention in place.

Resident #043 was observed by Inspector #683 on an identified date, and the identified fall prevention intervention was not in place.

On an identified date, the Administrator looked for the fall prevention intervention for resident #043 and was unable to locate it. The Administrator asked PSW #126 if the resident currently had any of the specific fall prevention interventions and they identified that they did not.

The home did not ensure that resident #043 had an identified fall prevention intervention in place at all times, as identified in their written plan of care. (683)

B) A review of the written plan of care for resident #046 identified that they were at a risk for falls and they had various interventions in place to try and prevent falls.

In an interview with PSW #126 on an identified date, and a review of resident #046's progress notes indicated that resident #046 did not have one of their fall prevention interventions in place for an identified reason.

Resident #046 was observed by Inspector #683 with the Administrator on an identified date, at an identified time, and the Administrator acknowledged that the resident did not have their identified fall prevention intervention in place.

The home did not ensure that resident #046 had their identified fall prevention intervention in place at all times, as identified in their written plan of care. [s. 6. (7)]

2. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in their plan related to toileting.

A review of the written plan of care in place for resident #012 at the time of the inspection identified that they had specific interventions in place related to toileting.

Resident #012 was observed for an identified time period on an identified date, and an identified intervention was not completed. In an interview with PSW #141 they identified that they asked the resident if the identified intervention was required and they indicated that it was not. In an interview with PSW #120, they identified that they checked the resident and the identified intervention was not required.

In an interview with Director of Nursing (DON) #101 on an identified date, they acknowledged that as per the Inspector's observations and interviews with the identified PSWs, the care set out in the plan of care related to toileting was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The following is further evidence to support CO #004 issued on November 13, 2018, during complaint inspection #2018_695156_0007 to be complied December 31, 2018.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #018 as specified in their plan related to continence care.

A review of Critical Incident (CI) log #024086-17 / Critical Incident System (CIS) #2931-000029-17 and of a written complaint submitted to the home, indicated that on an identified date, PSW #136 and #137 did not put an identified continence intervention in place for resident #018. As per the CI and written complaint, the resident indicated to the PSW staff that an identified intervention was not in place, but the staff did not listen and there was a negative impact on the resident.

A review of the written plan of care in place at the time of the incident identified that the resident required an identified level of assistance with continence care and had specific interventions in place related to continence care.

In an interview with DON #101 on an identified date, they acknowledged that resident #018's written plan of care in place at the time of the incident identified that staff were to apply an identified intervention at all times and that as per the CI and internal investigation notes, staff did not apply the identified intervention to resident #018, as per their written plan of care. [s. 6. (7)]

4. The licensee failed to ensure that care set out to manage resident #041's responsive

behaviours, was provided as specified in their plan.

On an identified date, resident #041 demonstrated a physical responsive behaviour towards resident #031, causing an injury to resident #031.

On an identified date, the physician ordered an identified intervention for resident #041 which was to be implemented at an identified time for an identified time period. In an interview with DON #101 and #105 it was shared the home increased the identified intervention on an identified date.

Invoice records were reviewed from an identified time period. It was documented that the identified intervention was not provided on two identified dates.

In an interview with PSWs working on resident #041's home area it was shared that they monitored resident #041 when the identified intervention was not in place but did not provide the identified intervention. In an interview with the Administrator it was shared the home did not have a process in place for when the identified intervention for resident #041 could not be implemented.

In an interview with DON #101 and #105 it was confirmed that the identified strategy developed to manage resident #041's responsive behaviours was not always implemented as specified in their plan. (583) [s. 6. (7)]

5. The licensee failed to ensure that when resident #017 was reassessed, their plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of CI log #004001-19 / CIS #2931-000008-19, indicated that on an identified date, resident #017 sustained a fall which resulted in an identified injury.

A review of the written plan of care in place for resident #017 identified that they were at risk of falls and had specific interventions in place to try and prevent falls. A review of a progress note from an identified date, and an observation of resident #017's room on an identified date, noted two specific fall prevention interventions that were in place, but were not identified in the resident's written plan of care.

In interviews with PSW #122, PSW #125 and Registered Practical Nurse (RPN) #123 on identified dates, they acknowledged that the two specific fall prevention interventions that

were observed in the resident's room and identified in the specific progress note, were current fall prevention interventions for the resident. In an interview with RPN #125 on an identified date, they noted that an identified intervention was not included in the written plan of care for the resident and it should have been.

In an interview with DON #101 on an identified date, they acknowledged that when a resident was reassessed, their written plan of care should be revised. Resident #017's written plan of care was reviewed with DON #101 and they identified that the interventions recognized in the progress note from an identified date should have been documented in resident #017's written plan of care.

The home did not ensure resident #017's written plan of care was revised to include two specific fall prevention interventions, after the resident was reassessed and their care needs changed. [s. 6. (10) (b)]

6. The licensee failed to ensure that resident #022 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A CI log #003925-17 / CIS #2931- 000001-17 was submitted to the Director on an identified date, related to improper care towards resident #022.

A review of the written plan of care, last reviewed on an identified date, indicated a focus for nursing rehabilitation restorative care (NRRC) for toileting, with a specific goal. A review of the resident assessment protocol (RAP) from an identified date, indicated the specific continence level of the resident. During an interview on an identified date, RPN #134 stated that resident #022 should have had a customized focus rather than the NRRC toileting care plan. During an interview with RPN #125, they stated that the resident should not have been on the NRRC toileting care plan and that the goal for the NRRC care plan did not meet the resident's needs. RPN #125 stated that the resident was not reassessed and the plan of care was not reviewed and revised when resident #022's care needs changed. [s. 6. (10) (b)]

7. When resident #037's care set out in the plan was removed from the plan of care and determined to be no longer necessary the licensee failed to ensure that this was based on a reassessment of resident #037.

Resident #037 had a known history of behaviours and interventions were put in place

related to a previous incident. In a progress note from an identified date, a resident from an identified home area made a complaint to staff about resident #037. It was documented by Registered Nurse (RN) #168 that they spoke to resident #037 and discussed guidelines around visiting the identified home area. It was documented that staff from the identified home area were aware of the guidelines.

In a conversation with RPN #151 and PSW #169 from the identified home area, it was noted that staff were not aware of any guidelines required for resident #037. Resident #037's plan of care was reviewed and no guidelines were identified. It was identified that specific care plan focuses were removed from the plan of care along with a number of interventions on an identified date.

The quarterly assessments were reviewed from an identified month, progress notes and documentation of risk management rounds (where the home identified that responsive behaviours were discussed) and no documented reassessment of resident #037 was found. In an interview with RN #168, it was shared that the resident still demonstrated a specific behaviour and it should still be identified in the resident's plan of care that they had a history of specific behaviours. The home did not ensure that when resident #037's care plan goals were removed and interventions were discontinued that they were based on assessed needs of the resident. [s. 6. (10) (b)]

8. The licensee failed to ensure that different approaches were considered in the revision of the plan of care post fall, when resident #003 was reassessed and the plan of care reviewed and revised, because care set out in the plan was not effective.

A review of CI log #008278-19 / CIS #2931-000013-19, indicated that on an identified date, resident #003 sustained a fall that resulted in an identified injury.

A review of the written plan of care for resident #003 on an identified date, indicated that the resident had specific interventions in place to try and prevent falls. The strategies that were in place at the time of the fall were not changed after the fall on an identified date, and no evidence was found to support different approaches were considered at that time.

On an identified date, resident #003 had a subsequent fall which resulted in an identified injury.

In an interview with RPN #102, they explained that resident #003 required an identified

level of assistance before and after the fall on an identified date, and no changes were made to the resident's strategies for fall prevention after the noted fall.

In an interview with DON #101 on an identified date, they indicated that when a resident has fallen, the expectation was that their written plan of care was updated under the fall risk section. DON #101 acknowledged that the care set out in resident #003's care plan related to falls was not effective at the time of the fall on an identified date, and other strategies were not considered afterwards as part of the assessment and revision of the plan of care.

The licensee failed to ensure that different approaches were considered to prevent further falls in the review and revision of the plan of care for resident #003 when the care set out in the plan of care was not effective. [s. 6. (11) (b)]

9. The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

The licensee failed to ensure that different approaches were considered in the review and revision of the plan of care for resident #003 when the care set out in the plan was not effective.

A complaint log #029655-18 / IL-61464-HA was submitted to the Director on an identified date, related to plan of care. A clinical record review indicated that resident #003 had an identified diagnosis and an identified CPS score. A review of resident #003's care plan last revised on an identified date, indicated a focus of identified behaviours and included interventions to respond to the identified behaviours. A progress note from an identified date and a review of the electronic treatment administrator record (ETAR) identified that resident #003 demonstrated behaviours around specific care areas on a number of identified dates.

During an interview on an identified date, RPN #102 stated that the resident demonstrated behaviours around specific care areas frequently and on an identified date, RPN #107 stated that the resident would demonstrate specific behaviors and specific assessments were not completed because of the identified behaviours. During an interview on an identified date, DON #101 stated that different approaches were not considered in relation to resident #003's identified behaviours and their plan of care was not reviewed and revised when the care was ineffective. (682) [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and any other time when the resident's care needs change or care set out in the plan is no longer necessary and to ensure that if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure resident #031 was protected from abuse by resident #041 related to CIS #2931-000014-19 / CIS #2931-000015-19 / CI log #008611-19.

For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

Resident #041's plan of care was reviewed and it was noted that resident #041 had a history of identified behaviours towards staff and other residents and their care plan identified specific triggers for their behaviours and included specific interventions to respond to their behaviours.

On an identified date, it was identified during the home's investigation that resident #041 demonstrated specific behaviours so staff implemented an intervention from their plan of

care. Shortly after this at an identified time, a physical altercation occurred between resident #041 and resident #031 which resulted in an injury to resident #031.

In an interview with the Administrator and DON #101 and #105 it was confirmed that resident #031 was not protected from physical abuse. [s. 19. (1)]

2. The following is further evidence to support CO #002 issued on September 11, 2018, during complaint inspection #2018_743536_0006 to be complied October 31, 2018.

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

A CI log #005262-18 / CIS #2931-000007-18, was submitted to the Director on an identified date, related to allegations of abuse towards resident #031 by PSW #191.

A review of the investigative notes related to the incident stated that on an identified date, PSW #190 was assisting PSW #191 with providing care to resident #031 when the resident demonstrated identified behaviours and PSW #191 responded in an identified manner.

During an interview on an identified date, the Administrator confirmed that the allegation was investigated by the DON on an identified date, at which time the allegation of abuse with no injury was substantiated. PSW #190 confirmed that they witnessed the identified incident between PSW #191 and resident #031 when they demonstrated responsive behaviours on the identified date. The home failed to protect resident #031 from abuse by PSW #191. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure the witnessed incident of abuse of a resident by resident #041 that was reported to the licensee was immediately investigated and appropriate action was taken in response to the incident.

On an identified date, at an identified time, an altercation was observed by staff between resident #041 and resident #031, which resulted in an identified injury to resident #031.

Resident #041 had identified responsive behaviours that had been previously demonstrated towards other residents and staff. It was documented the RN notified the DON of the altercation. Registered nursing staff notified the Power of Attorneys (POA's) and physician, and assessed the residents and provided medical interventions at the time of the incident.

The home's investigation package provided by DON #101 contained the CIS investigation which was submitted on an identified date, and a documented statement completed by PSW #165 on an identified date, of what occurred at the time of the incident.

In an interview with DON #101 and #105, Inspector #583 asked them to provide any evidence or information that identified what interventions were put in place to monitor resident #041 or what was done to ensure other residents on resident #041's home area were not at risk of harm for the first 24 hours after the incident occurred. No information

was provided.

Resident #041's clinical record identified that the physician ordered an identified intervention on an identified date, and that the home implemented the identified intervention and a second intervention on an identified date, at an identified time, approximately 24 hours after the incident occurred.

In an interview with the Administrator it was confirmed that the incident was reported to management and that an immediate investigation was not initiated. It was confirmed that appropriate action to monitor and ensure the safety of residents at risk of harm on resident #041's home area were not immediately implemented. [s. 23. (1)]

2. The following is further evidence to support CO #002 issued on September 11, 2018, during inspection 2018_743536_0006 to be complied October 31, 2018.

A) The licensee failed to ensure that suspected abuse of resident #024 that the licensee knew of was immediately investigated related to CIS #2931-000006-18 / CI log #004650.

On an identified date, PSW #150 observed an incident between resident #024 and an identified individual. In an interview with PSW #150 it was shared that there was a short period where the resident was not observed. PSW #150 shared that when they next observed the identified individual and resident they were talking and smiling. PSW #150 reported the incident to RPN #151, as resident #024 had an identified cognitive performance scale (CPS) score.

RPN #151 documented the incident occurred. It was noted that comfort was provided to the resident and no injury was found. It was not documented what questions were asked to the resident, what the resident's responses were, if it was reported to anyone, what action was taken to support the resident or what interventions to deal with the person who may have abused the resident.

At an identified time, it was documented that resident #024 was provided with an identified medical intervention and they responded in an identified manner.

In a note documented by the Nursing Manager of Program Development it identified that they became aware of the incident when reading the shift change report and directed the charge RN to assess the resident, start monitoring and provide emotional support.

At an identified time, it was documented by RN #152 that the resident stated specific details about the above-noted incident and they had an identified emotional response, but were unable to identify who the incident was with.

At the time of the inspection, Inspector #583 requested the home's investigation package. One document was provided which was a statement from PSW #150 of what they observed on the identified date. During the interview with the PSW it was confirmed that management requested this information and they documented it on an identified date.

In an interview with DON #101 and #105 it was confirmed that the home did not immediately investigate when a person had reasonable grounds to suspect abuse may have occurred or there was risk that it could occur. (583)

B) The licensee failed to ensure that suspected abuse of resident #024 and #025 that the licensee knew of was immediately investigated related to CIS #2931-000026-18 / CI log #021925-18.

A review of the clinical records, home's investigation notes and interview with staff #153 and #154 identified the following:
On an identified date, there was an incident between resident #026 and resident #024.
On the same identified date, there was an incident between resident #026 and resident #025.

Residents #024 and #025 had identified CPS scores and resided on an identified home area. At the time of the inspection no documentation could be found that resident #024 or #025 were interviewed during the investigation. Resident #026 had an identified CPS score and had identified behaviours.

In an interview with staff #153 and #154 it was shared that the incidents were reported to an identified manager and the DON.

The first documentation of the incident was found in resident #024, #025 and #026's clinical records in the progress notes on an identified date.

Inspector #583 requested the home's investigation package. Two documents were provided which included an interview with resident #026 completed one day later, and a description of what took place, which was not dated and did not identify who the

statement was from. It was later confirmed that staff #153 wrote the statement and that the management had requested a statement a number of days after the incident occurred.

In an interview with the DON #101 and #105 it was confirmed that the home did not immediately investigate when a person had reasonable grounds to suspect abuse may have occurred or there was risk that it could occur. (583)

C) The licensee failed to ensure that an alleged/suspected incident of abuse related to resident #032 that was reported was immediately investigated.

CI log #019549-18 / CIS #2931-000022-18 was submitted to the Director on an identified date, under the category of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. A review of the CI identified that on an identified date, PSW #155 reported an identified concern to the DON related to resident #032. As per the CI, PSW #155 indicated that they reported it to the nurse on the unit on an identified date, as they identified the concern while providing care to the resident. The CI further indicated that on an identified date, PSW #155 identified that the resident was upset and expressed concerns about their care. As per the CI, PSW #155 identified that it was reported to the RPN on the unit.

A review of the home's internal investigation notes identified an interview with resident #032 on an identified date, where they indicated that they felt that the identified concern was related to care provided by PSW #156 and identified concerns about the care they provided. The home's investigation notes and a review of the resident's electronic records identified that at the time of the incident, the resident had an identified CPS score.

A review of the electronic record for resident #032 identified a progress note from an identified date, where they indicated that they were upset about an identified intervention. A progress note from an identified date indicated that staff reported the resident had an identified concern. A review of a progress note from an identified date, which was documented by RN #152 indicated that the resident reported to the RPN concerns about the care that staff provided to them which they felt resulted in an identified concern. As per the progress note, an assessment was completed and an identified concern had previously been documented on an identified date.

DON #105 reviewed the CI, the home's internal investigation notes and the progress

notes for resident #032 at the request of Inspector #683. In an interview with DON #105 on an identified date, they acknowledged some of the inconsistencies in the available documentation, but acknowledged that at the time of the inspection, it appeared that the alleged incident of abuse was not immediately investigated when the resident reported concerns about the care they received and presented with an identified concern. [s. 23. (1) (a)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to develop and implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of accommodations, care, services, programs and goods provided to residents of the long-term care home.

While completing concurrent Complaint, Critical Incident System and Follow Up inspections it was noted that the long-term care home (LTCH) had not focused on a number of quality monitoring and improvement activities.

A) The Administrator was asked to provide the licensee's Quality Program guidance document(s) and in response provided the document #AM-06-02-02, titled "CQI Policy," which was part of the Administration Manual.

This document identified the following:
Statements
-The Continuous Quality Improvement (CQI) Program shall ensure all programs, services and activities of the Manor are continually monitored, audited and evaluated in order to

continually improve quality of care.
-The CQI Program shall identify and reduce risks and increase safety of the environment for residents, staff and members of the public.
-The CQI Program shall provide assurance to the staff and public that the quality of programs and services is being continually monitored and deficiencies identified and corrected.

Staff Responsibilities
-The Administrator has overall responsibility for the development and implementation of the multidisciplinary Continuous Quality Improvement Process.
-Under the direction of the Administrator each Department Head will be responsible for the development and implementation of a Continuous Quality Improvement Process within their own department. Each department will participate in the multidisciplinary team activities of the CQI process.

Monitoring Activities
-The Management team is responsible for the co-ordination and monitoring of the Continuous Quality Improvement Process, and has the responsibility and authority to inquire into problems and implement solutions, and to continually review CQI activities in each department and service provider and recommend changes if necessary.
-QI reports will be submitted to the Administrator on a quarterly basis for review and follow-up. On a quarterly basis a full CQI report will be prepared for the Quality Committee of the Board of Directors.

Department Participation Strategy:
-In conjunction with members of staff, each Department Head shall prepare and submit a monthly CQI report to the Management Team and the Professional Advisory Committee for review and follow up. The report will be reviewed with staff and posted in each department.

During discussions with DON #101 and DON #105, staff #166, staff #113 and staff #167, who were identified as Department Heads/Managers, they confirmed that they had not developed or implemented a Continuous Quality Improvement Process within their respective departments and had not participated in multidisciplinary team activities related to a CQI process prior to this inspection. During these discussions the Department Heads/Managers acknowledged they lacked a clear understanding of how to initiate a Continuous Quality Improvement Process within their department.

During discussions with the Administrator on an identified date, they verified/acknowledged/confirmed the following:
-They acknowledged the home had not completed any quality activities last year,
-They verified that Department Managers had not developed or implemented their individual department quality programs,
-They confirmed a multidisciplinary CQI process had not been developed or implemented,
-They acknowledged the Management Team had not fulfilled their responsibility to co-ordinate and monitor a CQI program,
-They acknowledged that the heads of the above noted departments lacked a clear understanding of how to develop a continuous quality program.
-They confirmed that a CQI report, that represented the quality activities in the home had not been prepared for the Quality Committee of the Board of Directors,
-They confirmed they had not co-ordinated strategic planning to identify goals, objectives, plans or auditing activities related to any CQI process prior to this inspection, and
-They confirmed they had not completed other CQI activities identified in the licensee's policy such as the implementation of a performance appraisal program to review the performance of staff and service providers.

B) At the completion of the Complaint, Critical Incident System and Follow Up inspections, it was noted that staff in the home had not been successful in completing a number of required activities to monitor, analyze, evaluate and improve the quality of the accommodation, care, services, programs and goods provided to residents, specifically, the following:

i) Staff had not been successful in monitoring and improving the quality of care and services when it was identified that six of the nine compliance orders that had been previously served to the licensee and were followed up at the time of these inspections, had not been returned to compliance with respect to the requirements identified in the Long-Term Care Homes Act 2007 and Ontario Regulation 79/10.

ii) Staff had not monitored or evaluated staff training requirements when it was identified that staff had not received training required in the Long-Term Care Homes Act 2007, and Ontario Regulation 79/10, in an identified number of areas that were identified as mandatory training requirements and staff had not completed an analysis, evaluation or plan to improve the orientation and training program, when they did not complete an annual evaluation or update the training and orientation program, as was required.

iii) Staff had not ensured the licensee's policies and procedures were evaluated and updated to ensure those documents provided clear directions to staff who provide care to the residents. The Administrator confirmed that the most current policies and procedures were located in the computerized repository.

At the time of this inspection the following registered staff confirmed to Inspector #129 and Inspector #583 that they did not have access to current policies and procedures in the computerized repository: RPN #114, RPN #125, RPN #142, RPN #116, RPN #107 and RN #118.

iv) Staff had not completed annual evaluations or updated the following programs/areas as was required: Abuse Prevention, Management of Complaints, Staffing Plan, Continence and Bowel Management Program, Management of Responsive Behaviours, as well as the Falls Prevention program.

The Administrator, Department Managers, registered staff, records and documents provided by the home as well as the outcome of concurrently inspected Complaint, Critical Incident System and Follow Up inspections confirmed that the licensee did not ensure they developed and implemented a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents. [s. 84.]

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. 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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention and management program that provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policies #RC-10-01-07, titled "Head Injury Routine," #RC-11-01-05, titled "Post Fall Assessment and Management," and #RC-11-01-02, titled "Falls Prevention and Management Program: The Interdisciplinary Team Roles and Responsibilities," which were part of the licensee's Falls Prevention and Management Program. Policy #RC-11-01-05 indicated that registered nursing staff were to initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that resulted in a confirmed or possible head injury. The HIR policy, #RC-10-01-07, indicated the frequency to monitor residents was every 30 minutes for one hour, if stable then every hour for the next three hours and if stable, every four hours for 48 hours. In addition, the policy outlined that staff were to: assess resident's pupils, note if they're more difficult to rouse than usual, any nausea and/or vomiting, if the resident was confused or more confused than usual, any headache that gets worse, any unusual twitching of arms or legs, unusual appetite, any actions felt to be bizarre or strange, any unusual drowsiness, and all findings were to be documented on the Neurovitals Record. Policy # RC-11-01-02 identified under RPN tasks, that staff were to update the fall risk assessment tools when completing the quarterly assessments and to update care plans as necessary.

A) A review of CI log #008278-19 / CIS #2931-000013-19, indicated that on an identified date, resident #003 sustained an unwitnessed fall in their room at an identified time. The resident was sent to hospital on an identified date, and they sustained an identified injury.

The written plan of care was reviewed and found resident #003 had a fall resulting in an injury on an identified date, and an identified number of unwitnessed falls on identified dates.

i) Resident #003's clinical record was reviewed and Neurological Flow Sheets (NFS) from identified dates were obtained for resident #003's identified falls. A review of the NFS identified that the assessments were not completed as per the outlined frequency.

In an interview with DON #101 on an identified date, they confirmed that the above noted policy was in place at the time of the identified falls for resident #003. DON #101 acknowledged that registered staff were expected to complete the HIR at the directed frequency. DON #101 acknowledged that the Neurological Flow Sheet had been recently updated and staff were not provided training. Inspector #750 reviewed the above noted NFS with DON #101 who confirmed that the assessments were not completed as per the policy.

The licensee failed to ensure that staff complied with the "Post fall Assessment and Management" and "Head Injury Routine" policies when completing the HIR assessments for resident #003 on the identified dates.

ii) A review of the written plan of care for resident #003 on an identified date indicated that two fall risk assessments were completed for this resident prior to their fall on an identified date. No further assessments were completed prior to the fall on the identified date, or immediately following.

In an interview with RPN #102 on an identified date, they acknowledged that fall risk assessments should be completed quarterly, when a resident falls and when a resident's status changes.

On an identified date, in an interview with DON #101, they confirmed that assessments, specifically fall risk assessments, were expected to be completed quarterly and with any change of status. Inspector #750 reviewed resident #003's fall risk assessment history with DON #101 on Point Click Care (PCC) and they acknowledged that the fall risk

The licensee failed to ensure that staff complied with the "Falls Prevention and Management Program: The Interdisciplinary Team Roles and Responsibilities" policy when fall risk assessments were not completed at the identified intervals for resident #003.

B) A review of CI log #004001-19 / CIS #2931-000008-19 identified that resident #017 had an unwitnessed fall on an identified date, which resulted in an identified injury. A review of the CI and the resident's written plan of care identified that they also had unwitnessed falls on other identified dates.

The clinical record for resident #017 was reviewed on an identified date, and Neurological Assessment Records (NAR) were found for the identified falls. On an identified date, RPN #123 explained NARs were used to assess residents who fell and required head injury routine follow up. All of the identified assessments were not completed as per the determined frequency.

In an interview with DON #101 on an identified date, they confirmed that the two policies noted above were the policies in place at the time of resident #017's falls. DON #101 noted that staff were expected to complete the post fall head injury routine assessment at the outlined frequency in the policy. Inspector #750 reviewed the identified NARs with DON #101 and they acknowledged that staff had not completed them as indicated and did not follow the policy.

The licensee failed to ensure that staff complied with the "Post Fall Assessment and Management" and "Head Injury Routine" policies when completing the identified head injury routine assessments for resident #017. [s. 8. (1) (a),s. 8. (1) (b)]

2. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10 s. 68 (2) (a) and in reference to LTCHA s. 11 (1), the licensee was required to have an organized program of nutrition care and dietary services and hydration that included the development and implementation of policies and

procedures relating to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the licensee's policy #RC-08-02, titled "Hydration Monitoring," last revised on an identified date, which was part of the licensee's nutrition care and dietary services program. The "Hydration Monitoring" policy stated:

"Other indications for registered dietitian (RD) referrals: [a specified amount of] meals consumed in three or more days."

A complaint log #009642-18 was submitted to the Director on an identified date, related to the care of resident #005.

A review of the clinical record for resident #005 indicated that they were at an identified nutritional risk related to identified diagnoses. A review of the POC documentation "Percentage of meals consumed" indicated that on identified dates, resident #005 consumed a specified amount of their meals per day. Further review indicated that referrals to the RD related to the change in intake on the identified dates were missing.

During an interview on an identified date, RPN #107 stated that referrals to the RD were done electronically or verbally and were made when a resident's intake was a specified amount for two to three consecutive meals. RPN #107 also stated, following a review of the electronic record, that they did not see any RD referrals sent electronically regarding the change in intake however, a referral could have been done verbally. During an interview on an identified date, the RD stated that they received referrals electronically however staff would also refer a resident verbally without any documentation. The RD also stated that if they received a referral verbally they would include that in their documentation. During an interview on an identified date, the DON #101, stated the expectation was for staff to initiate a RD referral when a resident consumed a specified amount of their meals. DON #101 could not provide any evidence that resident #005 was referred to the RD related to the identified dates.

The home did not ensure that a referral was sent to the RD when resident #005 consumed a specified amount of their meals in three or more days, as per their "Hydration Monitoring" policy. (682) [s. 8. (1) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, 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).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s.

76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received training as required by this section.

The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below.

In accordance with O. Reg 79/10 s. 222 (1) (a), a licensee of a long-term care home is exempt from the requirements under section 76 of the Act with respect to persons who fall under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act.

LTCHA, 2007, s. 2 (1) defines staff as persons who work in the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

In accordance with O. Reg 79/10 s. 222 (2), the licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1 related to the Residents' Bill of Rights, paragraph 3 related to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, paragraph 4 related to the duty under section 24 to make mandatory reports, paragraph 5 related to the protections afforded by section 26, paragraph 7 related to fire prevention and safety, paragraph 8 related to emergency and evacuation procedures and paragraph 9 related to infection prevention and control of subsection 76 (2) of the Act before providing their services.

A) The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

In an interview with DON #101 on an identified date, they indicated that the home used an employment agency to fill PSW, RPN or RN positions when scheduled shifts could not

be filled by the home's employees. The content of the orientation provided to agency PSWs, RPNs and RNs was reviewed which included two components: online training provided by the third party and an orientation completed in the home. Each were to be completed prior the staff being allowed to perform their responsibilities in the home.

The home's RN, RPN and PSW orientation checklists were reviewed which included direction on what training was required for orientation and had a trainer and staff sign off section that were to be initialed when completed. When reviewed, no content was found related to the home's policy to promote zero tolerance of abuse and neglect.

Orientation training records were reviewed for three agency staff members that worked multiple shifts in 2019 in the home. It was confirmed with DON #101 that agency RPN #127, agency RN #128 and agency RPN #129 did not receive training on the home's policy to promote zero tolerance of abuse and neglect before performing their responsibilities.

In an interview with DON #101 it was confirmed that training related to the home's policy to promote zero tolerance of abuse and neglect was not included in the orientation training provided to agency staff. (583)

B) A review of CI log #008725-17 / CIS #2931-000009-17, which was submitted to the Director on an identified date, included allegations of staff to resident abuse by PSW #112 to resident #014.

In an interview with the Administrator on an identified date, they indicated that the home used a third party for PSWs who provided a specified intervention residents. In an interview with the Manager of Recreation and Volunteer Services on an identified date, they indicated that PSW #112 worked at the home, beginning on an identified date, through an identified employment agency to provide a specified intervention to resident #014. On an identified date, they acknowledged that the home and the identified employment agency did not have any training and orientation records for PSW #112, in any of the required areas.

The home did not ensure that orientation was provided as required for PSW #112 in the areas of the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded by section 26, fire prevention and safety, emergency and evacuation procedures and infection prevention and control prior to them

providing services in the home. (683)

C) A review of CI log #000980-19/ CIS #2931000003-19, which was submitted to the Director on an identified date, included allegations of resident to resident abuse involving resident #025 and resident #030.

During an interview on an identified date, RPN #125 indicated that the home used a third party for PSWs who provided a specified intervention for resident #030. During an interview on an identified date, the Administrator identified that PSW #149 was scheduled on an identified date to provide the specified intervention for resident #030 related to responsive behaviours. A review of an identified invoice confirmed that PSW #149 worked at an identified time on an identified date. A review of the policy titled "Resident Approaches and Behaviours of Daily Living," from an identified date, stated; "All staff, including contractors providing direct care and volunteers, will be oriented/trained prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behaviour management as per LTCHA 2007."

During an interview on an identified date, PSW #149 denied receiving any training or orientation on the required areas prior to commencing their work in the home. During an interview on an identified date, the Manager of Recreation and Volunteer Services stated that orientation training was not provided to PSW #149 prior to them commencing work in the home.

The home did not ensure that orientation was provided as required for PSW #149 in the areas of the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded by section 26, fire prevention and safety, emergency and evacuation procedures and infection prevention and control prior to them providing services in the home. (682)

2. The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

The licensee failed to ensure that all staff in the home received training under s. 76 (2) 3, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and s. 76 (2) 4, the duty under section 24 to make mandatory reports at times and intervals provided for in the regulations. 2007, c.8, s. 76 (4)

In accordance with O. Reg. 79/10, s. 219 (1), the licensee was required to retrain all staff in the home annually for the purpose of s. 76 (4) of the Act.

A) Course completion and material content documents were reviewed titled "IWM Resident Abuse and Neglect.pdf." It was confirmed by the Manager of Recreation and Volunteer Services that all staff in the home were provided online access to complete this education which included the home's policy to promote zero tolerance of abuse and neglect of residents. As of an identified date, it was documented on the record that an identified number of staff did not complete the training.

In an interview with the Administrator on an identified date, it was confirmed that all staff in the home did not complete the required annual training on the home's policy to promote zero tolerance of abuse and neglect of residents in an identified year. (583)

B) Course completion and material content documents were reviewed for the following documents:
"Whistle Blowing Protection"
"Critical Incidents Part 1: Categories and Timelines for Reporting"
"Critical Incidents Part 2: Mandatory Reporting Responsibilities and Procedures by Surge Learning"
"Resident Abuse and Neglect"

In an interview with the Administrator on an identified date, it was confirmed that completion of the training noted above was the home's required annual training related to the duty under section 24 to make mandatory reports. It was confirmed that not all staff in the home completed this required training in an identified year.

The home had a compliance order (CO) issued during Inspection #2018_743536_0006 and the home was directed to ensure all staff in the home completed training on mandatory reporting by an identified date. In an interview with the Administrator on an identified date, it was confirmed that a significant number of staff completed this training in an identified month, after the compliance due date. (583)

3. The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

The licensee failed to ensure that all staff who provide direct care to residents, as a

condition of continuing to have contact with residents, received training in 1. Abuse recognition and prevention, 2. Mental Health issues, including caring for persons with dementia, 3. Behaviour management and 6. Any other areas provided for in the regulations, at intervals provided for in the regulations.

In accordance with O. Reg. 79/10, s. 221 (2) 1, the licensee was required to retrain all direct care staff in the home annually. In accordance with O. Reg. 79/10, s. 221 (2) 2, the licensee did not assess the individual training needs of staff members as was confirmed by the Administrator during an interview.

A) The licensee failed to ensure that all staff who provided direct care to residents received training in 1. Abuse Recognition and Prevention.

Course completion records and material content records that were provided by the home were reviewed titled "Resident Abuse and Neglect." It was documented as of an identified date, an identified number of staff did not complete the training.

In an interview with the Administrator on an identified date, it was confirmed that this specific training module contained the education related to abuse recognition and prevention and that not all required direct care staff completed the required annual training.

B) The licensee failed to ensure that all staff who provided direct care to residents received training in 2. Mental Health Issues, including care for persons with Dementia and 3. Behaviour Management.

Course completion records and material content records provided by the home were reviewed for the following documents:
"Dementia Behaviour Management"
"Working with Dementia Part 2: How to approach residents"

In an interview with the Administrator on an identified date, it was confirmed that these were the specific training modules that contained the education related to mental health issues, including care for persons with dementia and related to behaviour management. It was confirmed that all direct care staff did not complete the required training as of an identified date.

The home had a CO issued during Inspection #2018_743536_0006 and the home was

directed to ensure all direct care staff in the home completed training by an identified date, on abuse recognition and prevention and behaviour management. In an interview with the Administrator on an identified date, it was confirmed that a significant number of staff completed this training in an identified month, after the compliance due date.

C) The licensee failed to ensure that all staff who provided direct care to residents received training in 6. Any other areas provided for in the regulations.

i) In accordance to O. Reg. 79/10, s. 221 (1) 1 and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training in the area of Falls Prevention and Management.

Course completion records and material content records that were provided by the home were reviewed titled "Falls Prevention Part 1: An introduction." It was documented as of an identified date, an identified number of direct care staff had not completed this training.

In addition, the home required all registered nursing staff to complete the following as part of the home required falls prevention and management training:
"Falls Prevention Part 2: Fall Risk Factors in Seniors"
"Falls Prevention Part 3: Assessment and Interdisciplinary Roles"
"Falls Prevention Part 4: Interventions in Minimizing Risk for Falls and Fall-Related Injuries"
It was documented that an identified number of registered nursing staff did not complete the above noted training in an identified year.

In an interview with the Administrator on an identified date, it was confirmed that all direct care staff did not complete annual training in Falls Prevention and Management in an identified year.

ii) In accordance to O. Reg. 79/10, s. 221 (1) 2 and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Management.

Course completion records and material content records that were provided by the home were reviewed titled, "Skin Care and Pressure Ulcers for Direct Care Staff" and it was documented that an identified number of PSWs did not complete the training for an identified year.

In an interview with the Administrator on an identified date, it was confirmed that RPNs and RNs had not been assigned any training to complete and that the home had not created Skin and Wound Management training for registered nursing staff to complete. It was confirmed that all direct care staff did not complete annual training in Skin and Wound Management in an identified year.

iii) The licensee failed to ensure that all staff who provided direct care to residents received training in 6. Any other areas provided for in the regulations.

In accordance to O. Reg. 79/10, s. 221 (1) 3, the home was required to provide all staff who provide direct care to residents with annual training in the area of continence care and bowel management.

Course completion records and material content records that were provided by the home were reviewed titled "Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) Continence Care and Bowel Management." It was documented as of an identified date, an identified number of direct care staff had not completed this training. Further record review included an email from an identified date, provided by DON #101 that stated that there were an identified number of direct care staff and that an identified number of direct care staff were not assigned to the OANHSS continence care and bowel management course.

In an interview on an identified date, DON #101 confirmed that all direct care staff did not complete annual training in continence care and bowel management in an identified year.

iv) In accordance to O. Reg. 79/10, s. 221 (1) 4. and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training in the area of Pain Management, including pain recognition of specific and non-specific signs of pain.

Course completion records and material content records that were provided by the home were reviewed titled, "Module 1 The Pain Experience: A Module for Direct Care Staff" and it was documented that an identified number of staff did not complete the training.

In an interview with the Administrator on an identified date, it was confirmed that all direct care staff did not complete annual training in pain recognition of specific and non-specific signs of pain.

v) In accordance to O. Reg. 79/10, s. 221 (1) 5 and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training 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.

Course completion records and material content records that were provided by the home were reviewed titled, "Restraints and PASDs: A Module for Direct Care Staff in Long Term Care Ontario only (a presentation by surge learning)," and it was documented that an identified number of staff did not complete the training.

In an interview with the Manager of Programs, it was confirmed that all direct care staff who apply physical devices did not complete annual training, including the application of identified physical devices. (583) [s. 76.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI log #005262-18 / CIS #2931-000007-18 was submitted to the Director on an identified date, related to allegations of abuse towards resident #031 by PSW #191.

A review of the licensee's policy #AM-02-01-08, titled "Zero Tolerance of Abuse and Neglect," last revised on an identified date, stated: "Staff and board member(s) must immediately report all alleged, suspected or witnessed incidents of:
(a) abuse of a resident by anyone, and
(b) neglect of a resident by a staff member of the home.
Employee(s) or Board Members who are reporting that they have witnessed or suspect alleged incident of resident abuse or neglect:
Report any witnessed, suspected, or alleged abuse to a supervisor/manager, Administrator, immediately."

A review of the investigative notes related to the incident stated that on an identified date, PSW #190 was assisting PSW #191 with providing care to resident #031 when the resident demonstrated identified behaviours and PSW #191 responded in an identified manner. During an interview on an identified date, RN #118 stated that the allegation of abuse was not reported to them until an identified date, which was a specific number of days after the witnessed incident. During an interview on an identified date, PSW #190 confirmed that they should have reported the incident immediately but waited the identified number of days for an identified reason. During an interview on an identified date, both RN #118 and DON #101 confirmed the requirements for immediate reporting and confirmed that this was not completed. The home failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used resident #044 and #045's device in accordance with manufacturers' instructions.

A) On an identified date, Inspector #583 observed resident #045 positioned in an identified mobility device, and they were unsupervised. They were observed with an identified physical device in place which was observed to be applied incorrectly. DON #105 observed the resident's identified physical device and confirmed it was not applied correctly. Resident #045's plan of care was reviewed and the identified physical device was assessed by the home to be used for an identified purpose.

B) On an identified date, resident #044 was observed sitting in their identified mobility device with an identified physical device in place which was observed to be applied incorrectly. RN #118 observed the physical device and confirmed it was not applied correctly.

Resident #044's plan of care was reviewed and the physical device was assessed by the home to be used for an identified purpose.

The Physiotherapist (PT) provided the instructions for the identified physical device, which indicated the identified physical device was to be adjusted a specific way. The PT shared the home's expectation was that the physical device should fit a specific way.

Resident #044 and #045's identified physical devices were not applied by staff in accordance to the manufacturers' instructions. [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that when staff had reasonable grounds to suspect abuse of resident #024 and #025 by resident #026 had occurred that the information on which it was based was immediately reported to the Director.

A review of the clinical records, home's investigation notes and interview with staff #153 and #154 indicated that on an identified date, an incident occurred between resident #024 and #026 and a separate incident between resident #025 and #026.

Residents #024 and #025 had identified CPS scores and resided on an identified home

area.

In an interview with staff #153 and #154 it was shared that the incidents were reported to an identified manager and DON at an identified time.

The critical incident was reported to the Director on an identified date at an identified time. In an interview with DON #101 and #105 it was confirmed that when the staff had reasonable grounds to suspect abuse, it was not immediately reported to the Director. [s. 24. (1)]

2. The licensee failed to ensure that when staff had reasonable grounds to suspect that physical abuse of resident #031 occurred by anyone that resulted in harm, that the information on which it was based was immediately reported to the Director.

On an identified date at an identified time, staff observed an altercation between resident #041 and resident #031 which resulted in an identified injury for resident #031.

The CIS #2931-000014-19 was first reported by DON #101 on an identified date, at an identified time. In an interview with the Administrator and DON #101 and #105 it was confirmed that the abuse of resident #031 was not immediately reported to the Director. [s. 24. (1)]

3. The licensee failed to ensure that when staff had reasonable grounds to suspect that physical abuse of resident #032 occurred by anyone that resulted in harm or risk of harm to the resident, that the information on which it was based was immediately reported to the Director.

CI log #019549-18 / CIS #2931-000022-18 was submitted to the Director on an identified date, under the category of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. A review of the CI indicated that on an identified date, PSW #155 reported an identified concern to the DON related to resident #032. As per the CI, PSW #155 indicated that they reported it to the nurse on the unit on an identified date, as they identified the concern while providing care to the resident. The CI further indicated that on an identified date, PSW #155 noted that the resident was upset and expressed concerns about their care. As per the CI, PSW #155 identified that it was reported to the RPN on the unit.

A review of the home's internal investigation notes identified an interview with resident

#032 on an identified date, where they indicated that they felt that the identified concern was related to care provided by PSW #156. The home's investigation notes and a review of the resident's electronic records indicated that at the time of the incident, the resident had an identified CPS score.

A review of the electronic record for resident #032 identified a progress note from an identified date, where they indicated that they were upset about an identified intervention. A progress note from an identified date indicated that staff reported the resident had an identified concern. A review of a progress note from an identified date, which was documented by RN #152, indicated that the resident reported to the RPN concerns about the care that staff provided to them which they felt resulted in an identified concern. As per the progress note, an assessment was completed and an identified concern had previously been documented on an identified date. The alleged incident was not reported to the Director on the identified date.

DON #105 reviewed the CI, the home's internal investigation notes and the progress notes for resident #032 at the request of Inspector #683. In an interview with DON #105 on an identified date, they acknowledged some of the inconsistencies in the available documentation, but acknowledged that at the time of the inspection, it appeared that the alleged incident of abuse was not immediately reported to the Director. [s. 24. (1)]

4. The licensee failed to ensure that RN #118 who had reasonable grounds to suspect that abuse of resident #031 by PSW #191 occurred that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A CI log #005262-18 / CIS #2931-000007-18, was submitted to the Director on an identified date, related to allegations of abuse towards resident #031 by PSW #191.

A review of the investigative notes related to the incident stated that on an identified date, PSW #190 was assisting PSW #191 with providing care to resident #031 when the resident started demonstrating responsive behaviours and PSW #191 responded in an identified manner. During an interview on an identified date, the Administrator confirmed that the allegation was investigated by the DON on an identified date, at which time the allegation of abuse was substantiated. The allegation of abuse was not reported to the Director as required. PSW #190 did not report the incident to RN #118 until an identified date, after the witnessed incident.

During an interview on an identified date, RN #118 stated that on an identified date, PSW #190 informed them of the incident that occurred on an identified date. RN #118 alerted the DON on-call of the incident electronically and did not notify the Director immediately. The Director was notified the following day. During an interview on an identified date, both RN #118 and DON #101 confirmed the requirements for immediate reporting and confirmed that this was not completed.

The home did not report the allegation of abuse to the Director as required, as confirmed during an interview with RN #118, on an identified date. [s. 24. (1)]

5. The licensee failed to ensure that a person who had reasonable grounds to suspect that improper care that resulted in risk of harm to resident #027 was immediately reported to the Director.

On an identified date, at an identified time, the licensee notified the Director of an incident identified as "Errors in administration of medication that altered a resident's health status," when CIS #2931-000012-19 was submitted for an incident that occurred on an identified date.

Following a review of the above noted CIS, resident #027's clinical record, a medication incident report related to the incident, as well as conversations held with staff aware of the incident, the following was confirmed:
- On an identified date, RPN #139 administered an identified number of medications to resident #027 that had not been prescribed for the resident to receive.
- The above noted medication error was identified by staff who contacted the on call physician.
- Resident #029 was monitored and was transferred to hospital for assessment at an identified time.

The licensee failed to notify the Director for an identified time period following an incident of improper care of resident #027 when the resident was administered medications that were not prescribed for them to take. The incident resulted in a risk of harm and a change in condition for which the resident was transferred to hospital. [s. 24. (1) 1.]

6. The licensee failed to ensure that staff who had reasonable grounds to suspect that neglect of resident #016 by staff that resulted in a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

Staff of the licensee had reasonable grounds to suspect that resident #016 had been neglected when the resident reported to a RN at an identified time on an identified date, that care was not provided to them in a specific area, for an identified time period. The RN forwarded this information to the DON in an email. The DON contacted the after-hours emergency pager an identified number of hours later to inform the Director of the incident. The Administrator verified that they believed the resident was neglected when they signed a CIS on an identified date, which indicated a report to the Director was being made under the mandatory category of "Abuse/Neglect" and subcategory "Staff to resident."

Resident #016's plan of care indicated that they required an identified level of assistance with a specific care area, that they were at risk for developing an identified condition due to an identified diagnosis, and identified a specific goal related to the identified care area.

At the time of this inspection the Administrator reviewed the above noted records and verified that the Director was not immediately notified of a suspicion that resident #016 had been neglected when staff failed to provide care in an identified area to the resident over an identified period of time. [s. 24. (1) 2.]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure a plan of care was based on, at a minimum, interdisciplinary assessment of skin condition, including altered skin integrity.

While inspecting CI log #011357-17 related to CIS #2931-000013-17, concerns were identified related to resident #013's skin and care concerns.

A review of clinical documentation included several notes in relation to the resident's skin condition and indicated that staff did not initiate skin assessments following the above noted changes in the resident's skin integrity, a care plan focus related protecting the residents skin was not initiated and there were no care interventions implemented to protect the resident from injury to their skin.

At the time of this inspection the Administrator was unable to provide evidence that the above noted activities had been initiated.

Resident #013's plan of care was not based on an assessment of the skin injuries the resident sustained, the risk for ongoing skin injuries or care interventions to prevent recurring skin injuries. [s. 26. (3) 15.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of health conditions, including altered skin integrity, with respect to the resident, to be implemented voluntarily.

WN #11: 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 following was 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: 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.

In accordance with O. Reg. 79/10 s. 48 (1), the home was required to have a falls prevention and management program and a continence care and bowel management program.

A) A CI log #003925-17 / CIS #2931- 000001-17 was submitted to the Director on an identified date, related to the care of resident #022.

Inspector #682 requested the annual continence care and bowel management program evaluation for an identified year. RPN #134 provided the licensee's continence team meeting minutes as the evaluation of their program. A review of the continence care team meeting minutes from identified dates did not include an annual evaluation of the continence care and bowel management required program identified under section 48 (1) 3 of O. Reg. 79/10.

During an interview on an identified date, the Administrator stated that they thought that the annual evaluation of the continence care and bowel management program had been completed for the identified year, but they could not provide any documentation that would indicate that any evaluation had been completed. The Administrator confirmed that the continence care and bowel management required program identified under section 48 (1) 3 of O. Reg. 79/10 was not completed for the identified year.

B) Inspector #750 requested a copy of the Falls Prevention and Management program evaluation for an identified year from DON #101. On an identified date, DON #101 reported the home did not have a Falls Program evaluation for the identified year. At the time of the inspection, there was no evidence to support that the home completed a program evaluation for the Falls Prevention and Management program in the identified year. [s. 30. (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 to ensure that the falls prevention and management program and the continence care and bowel management program are evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of residents with responsive behaviours.

In accordance with O. Reg. 79/10, s. 53 (3) the licensee shall ensure that (b) at least annually, the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (c) a written record is kept relating to each evaluation, under clause (b) 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. 53 (3).

A CI log #000980-19 / CIS #2931000003-19, was submitted to the Director on an identified date related to allegations of resident to resident abuse involving resident #025 and resident #030.

During an interview on an identified date, the Administrator stated that they did not complete an annual evaluation of the responsive behaviour management program. The Administrator confirmed that the responsive behaviour management program identified under section 53 (3) (b) of O. Reg. 79/10 was not completed for 2018. [s. 53. (3) (b)]

2. The licensee failed to ensure that for resident #030 demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that resident #030's responses to interventions were documented. O.Reg. 79/10, s.53 (4)

CI log #000980-19 / CIS #2931000003-19 was submitted to the Director on an identified date related to allegations of resident to resident abuse involving resident #025 and resident #030.

A clinical record review indicated that resident #030's care plan included a focus of an identified behavioural response and included strategies to respond to the identified behaviours. A review of the policy titled "Resident Approaches and Behaviours of Daily Living," from an identified date, stated;
"observe and document the resident's response to the care plan strategies, this can include: observation and documenting observations in charts and progress notes."

During an interview on an identified date, DON #101 stated PSWs that were assigned a specific task were required to complete the charting at identified intervals. Further review of resident #030's charting did not include any documentation or signatures at identified times for seven identified dates. During an interview on an identified date, DON #101 confirmed that the assessments of resident #030's behaviour were not documented on the identified dates and the home did not ensure that resident #030's assessments and responses to interventions were documented. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and that for each resident demonstrating responsive behaviours, that strategies are developed and implemented to respond to these behaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #13: 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 a written record was kept for the January-December 2018 evaluation of the effectiveness of the licensee's policy under section 20 of the LTCHA 2007, that included the dates that the changes and improvements were implemented.

At the time of this inspection the Administrator provided a copy of the licensee's January-December 2018 evaluation of the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents. During a meeting with the Administrator on an identified date, a review of the document was completed. It was identified and verified that "Goals and Objectives for the Period Under Review" were identified that included improvements made as well as a "Summary of Changes Made/Accomplishments" were identified; however, there were no dates identified when the changes and improvements were implemented. [s. 99. (e)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint made to the licensee concerning the care of resident #018 was investigated and responded to within 10 business days of

the receipt of the complaint.

A review of a written complaint addressed to the DON, from an identified date, indicated concerns related to care not being provided towards resident #018 on an identified date.

In an interview with DON #101 on an identified date, they acknowledged that the letter from an identified date was submitted to DON #105, and they were informed about the letter, but assumed it was about a different concern that was previously addressed. DON #101 confirmed that the written complaint submitted to the home on an identified date, related to care concerns for resident #018, was not investigated and responded to within 10 business days of the receipt of the complaint, due to some miscommunication. [s. 101. (1) 1.]

2. The following non-compliance was identified in complaint inspection #2019_661683_0007 and is being issued in this report.

The licensee failed to ensure that a response was made to the person who made a complaint concerning the care of a resident or the operation of the home, indicating what the licensee had done to resolve the complaint or that the licensee believed the complaint to be unfounded and the reasons for the belief.

While inspecting complaint log #020837-18, it was identified that resident #010's designated Substitute Decision Maker (SDM) submitted a complaint to the Administrator on an identified date. The Administrator subsequently forwarded the complaint to the Director. A review of the complaint indicated the SDM identified concerns related to the care of resident #010.

A review of resident #010's computerized clinical record confirmed that there was not a notation to indicate that a response to the issues identified in the identified complaint had been provided to the SDM.

During an interview with resident #010's SDM on an identified date, they confirmed that they did not recall receiving a response to their complaint and following a review of their records confirmed that they had not made a notation that they had received a response from the home.

At the time of this inspection and during an interview with the Administrator they confirmed that they were unable to provide any evidence that a response to the above

noted complaint was provided to the resident's SDM. [s. 101. (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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response provided within 10 days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents the investigation shall be commenced immediately, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as possible the circumstances of an unexpected or sudden death of resident #015, resident #028 and resident #029.

A) While inspecting CI log #014120-17, associated with CIS #2931-000018-17, related to the sudden death of resident #015, the following was noted:

Resident #015's clinical record verified that on an identified date, they were noted to be deceased. Records maintained by the Ministry of Health and Long-Term Care (MOHLTC), specifically, after hours calls received from Long Term Care Homes,

indicated that the licensee contacted the MOHLTC at an identified time on an identified date, and reported the unexpected death of resident #015. The licensee then submitted a CIS report on an identified date, identified as an unexpected death to inform the Director of the detailed circumstances of resident #015's death.

At the time of this inspection the Administrator reviewed the above noted records and verified that the Director was not immediately notified of the sudden death of resident #015. (129)

B) Resident #028's clinical record indicated the resident deceased on an identified date. A review of the licensee's "Resident Death Registry" indicated staff documented an identified cause of the resident's death, the death was not considered a Coroner case and the Institutional Patient Death Record (IPDR) had been completed.

A review of resident #028's plan of care that included; a review of documentation made by registered staff in progress notes over the period of a month prior to the resident's death and the computerized care plan that was in place at the time, indicated there was no documented evidence that the resident's care focus was palliative in nature or that staff expected the resident's death.

On an identified date, while in conversation with DON #101, they verified that they did not expect the resident's death at the time and also verified that the information recorded in the "Resident Death Registry" related to the cause of death would have been recorded from the Death Certificate. The DON also confirmed that they had not notified the Director of the death of resident #028. (129)

C) Resident #029's clinical record indicated the resident deceased on an identified date. A review of the licensee's "Resident Death Registry" indicated staff documented an identified cause of the resident's death, the death was not considered a Coroner case and the IPDR had been completed.

A review of resident #029's plan of care that included; a review of documentation made by registered staff in progress notes over the period of a month prior to the resident's death and the computerized care plan that was in place at the time, indicated there was no documented evidence that the resident's care focus was palliative in nature or that staff expected the resident's death.

On an identified date, while in conversation with DON #101, they verified that they did not

expect the resident's death at the time and also verified that the information recorded in the "Resident Death Registry" related to the cause of deat would have been recorded from the Death Certificate. The DON also confirmed that they had not notified the Director of the death of resident #029. [s. 107. (1) 2.]

Additional Required Actions:

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

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, medication administration observations were made during medication pass at an identified time on an identified home area. RPN #143 moved the medication cart from the locked medication room to the public walkway between the dining room and the resident lounge, which also was noted to be close to the door entering and exiting the home area. At this time it was noted that there were a number of residents nearby. RPN #143 unlocked the medication cart and then was noted to leave the medication cart unlocked while they went to retrieve an identified item.

RPN #143 confirmed that they had not maintained eye contact with the medication cart and that they had left the medication cart unlocked when they went to retrieve the identified item. [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program, specifically outbreak management.

On an identified date, during a confirmed outbreak at the home, Inspector #750 observed an identified number of residents gathered in an identified home area for an identified activity program. DON #101 indicated that the identified home area had symptomatic residents.

The home's policy #IC-05-01-0, titled "Outbreak Management," from an identified date provided an overview of the management of ill residents and staff during an outbreak, which included restricting contact between ill residents and well residents. Specifically, the policy identified that group programming be cancelled and programming be restricted to one to one with the asymptomatic residents on the affected unit(s).

In an interview with DON #101 on an identified date, they indicated that during an outbreak programs were to be one to one and recreation staff were to visit the affected unit at the end of the day. Inspector #750 informed DON #101 of the observation made on the identified date and DON #101 acknowledged that group activities should not be taking place during an outbreak, and that the discussed observation was not compliant with the home's policy.

The licensee failed to ensure that all staff participated in the implementation of the outbreak management program, as part of the Infection Prevention and Control (IPAC) program, when group activities were not cancelled on the identified home area during a confirmed outbreak on an identified date. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when they received a written complaint concerning the care of resident #018, it was immediately forwarded to the Director.

A review of a written complaint addressed to the DON identified concerns related to care not being provided to resident #018 on an identified date and included an allegation of neglect.

In an interview with DON #101, they acknowledged that the identified written complaint was submitted to DON #105, and they were informed about the written complaint, but assumed it was related to a written complaint from another date, which was previously addressed.

In an interview with DON #101 on an identified date, they acknowledged that the written concerns raised in the complaint submitted to the home on an identified date were different than the concerns identified in the letter from an identified date. DON #101 acknowledged that when the home received a written complaint concerning the continence care for resident #018 and allegations of neglect on an identified date, that it was not immediately forwarded to the Director. [s. 22. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring techniques when assisting residents.

A review of CI log #008038-17 / CIS #2931-000008-17 identified an allegation of staff to resident #002 abuse.

A review of the home's internal investigation notes identified an interview with PSW #109, where they indicated that on the identified date, they provided care to the resident and then transferred them to their identified mobility device. PSW #109 identified that the resident had an area of altered skin integrity in an identified area and when they transferred them that area started bleeding.

As per the home's internal investigation notes, PSW #109 and PSW #110 both identified in interviews that resident #002 required an identified level of assistance with transfers. A review of the resident's written plan of care in place at the time of the incident identified that they required an identified level of assistance with transfers, which was different than that reported by PSW #109 and PSW #110. In an interview with PSW #109 on an identified date, they could not remember how they transferred the resident on the identified date.

In an interview with the Administrator on an identified date, they confirmed that the written plan of care in place for resident #002 at the time of this incident indicated that the resident required an identified level of assistance with transfers and they acknowledged that as per the internal investigation notes, their understanding was that on an identified date, resident #002 was not transferred by PSW #109 as they should have been, as per their written plan of care.

The home did not ensure that PSW #109 used safe transferring techniques when they transferred resident #002 on an identified date. [s. 36.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #022 who required continence care products had sufficient changes to remain clean, dry and comfortable.

A CI log #003925-17 / CIS #2931-000001-17 was submitted to the Director on an identified date, related to improper care/neglect towards resident #022.

A review of the investigative notes indicated that on an identified date, resident #022 was incontinent and requested that PSW #138 assist them to change their continence product. Resident #022 was not provided assistance and was left in a soiled continence product until an identified time. During an interview on an identified date, PSW #135 stated that resident #022 required an identified level of assistance with continence care and continence product changes. During an interview on an identified date, RPN #102 stated that PSW #138 informed them that they required assistance with resident #022 but that they were busy at the time. RPN #102 also stated that they expected resident #022 to request assistance again and they did not. During an interview on an identified date, DON #101 stated that PSW #138 had informed RPN #102 that they required assistance with resident #022. It was expected that RPN #102 assist PSW #138 in relation to resident #022's needs immediately or find an alternate staff to provide assistance immediately. The DON #101 confirmed that on an identified date, resident #022 did not have sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy titled "Zero Tolerance of Abuse and Neglect," included the required information.

Following a review of the above noted policy the Administrator confirmed that the licensee's policy did not contain the following information:
-procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected,
-procedures and interventions to deal with persons who have abused or neglected or allegedly abuse or neglected residents,
-measures and strategies to prevent abuse and neglect and,
-training and retraining requirements for all staff including, the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care as well as situations that may lead to abuse and neglect and how to avoid them. [s. 96.]

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683), AILEEN GRABA (682), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129), STACEY GUTHRIE (750)
Inspection No. / No de l'inspection :	2019_661683_0008
Log No. / No de registre :	003925-17, 008038-17, 008725-17, 011357-17, 013258-17, 014120-17, 016521-17, 024086-17, 004650-18, 005262-18, 019549-18, 021925-18, 029083-18, 029084-18, 029085-18, 029088-18, 029089-18, 030798-18, 030799-18, 030801-18, 000980-19, 004001-19, 007426-19, 008278-19, 008611-19, 008843-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 16, 2019
Licensee / Titulaire de permis :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Susan Hastings

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To Idlewyld Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_695156_0007, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Ensure that the care set out in the plan of care for resident #012 and any other resident related to toileting is provided to them as specified in the plan.

2. Ensure that resident #043, #046 and any other resident's identified fall prevention interventions are applied according to their plan of care.

3. Ensure that resident #043 and any other resident's identified fall prevention interventions are in place and in working order as per their plan of care.

4. Develop and implement an auditing process to ensure that resident #043 and #046 have their identified fall prevention interventions in place as per their plan of care and that resident #012 is being toileted as per their written plan of care. Documentation is to be maintained of who completed the audits, when the audits were completed, and any action that was taken as a result of the audits.

5. Ensure that the care set out in the plan of care for resident #041 and any other resident related to an identified responsive behaviour intervention is provided to them as specified in the plan.

6. Develop and implement a written plan related to the home's process for an identified responsive behaviour intervention to ensure that residents requiring

the identified intervention are not left unattended. The plan, at a minimum, is to include how the intervention will be implemented so that residents are not left unattended when the intervention is not available. The plan is to be communicated to all direct care staff in the home.

7. Ensure that if staff are working with resident #041, or any other resident, from an employment agency or other third party, that they are provided access to, at a minimum, the resident's care plan in relation to their responsive behaviours including any behavioural triggers identified and strategies developed to respond to their behaviours, where possible.

8. Develop and implement an audit at a frequency and schedule as determined by the licensee to ensure that staff follow the above noted plan related to the home's process for the identified responsive behaviour intervention. Records are to be maintained of all completed audits.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO#004 from inspection #2018_695156_0007 issued on November 13, 2018, with a compliance date of December 31, 2018.

The licensee was ordered to be complaint with s. 6 (7) of Ontario Regulation 79/10.

Specifically, the licensee was ordered to ensure that care set out in the plans of care for residents #002 and #003 and all other residents, related to identified interventions was provided to the residents as specified in the plans.

The licensee failed to complete all steps in CO #004.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to identified fall prevention interventions.

A) A review of the written plan of care for resident #043 identified that they were at risk for falls and had various interventions in place to try and prevent falls.

i) At an identified time, on an identified date, an observation was made of resident #043. At an identified time, Inspector #683 and the Administrator observed the resident's room and an identified fall prevention intervention was noted to be in place, but not connected correctly. At an identified time PSW #126 confirmed, in the presence of the Administrator, that the identified fall prevention intervention was not in working order since it was not connected correctly.

The home did not ensure that the identified fall prevention intervention for resident #043 was connected correctly and in working order on an identified date, as identified in their written plan of care. (683)

ii) A review of the clinical record for resident #043 identified progress notes from an identified date, which indicated that a specific fall prevention intervention was not in place.

In an interview with PSW #126 on an identified date, they indicated a specific reason as to why resident #043 did not have their identified fall prevention intervention in place.

Resident #043 was observed by Inspector #683 on an identified date, and the identified fall prevention intervention was not in place.

On an identified date, the Administrator looked for the fall prevention intervention for resident #043 and was unable to locate it. The Administrator asked PSW #126 if the resident currently had any of the specific fall prevention interventions and they identified that they did not.

The home did not ensure that resident #043 had an identified fall prevention intervention in place at all times, as identified in their written plan of care. (683)

B) A review of the written plan of care for resident #046 identified that they were at a risk for falls and they had various interventions in place to try and prevent falls.

In an interview with PSW #126 on an identified date, and a review of resident #046's progress notes indicated that resident #046 did not have one of their fall

prevention interventions in place for an identified reason.

Resident #046 was observed by Inspector #683 with the Administrator on an identified date, at an identified time, and the Administrator acknowledged that the resident did not have their identified fall prevention intervention in place.

The home did not ensure that resident #046 had their identified fall prevention intervention in place at all times, as identified in their written plan of care. [s. 6. (7)]

2. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in their plan related to toileting.

A review of the written plan of care in place for resident #012 at the time of the inspection identified that they had specific interventions in place related to toileting.

Resident #012 was observed for an identified time period on an identified date, and an identified intervention was not completed. In an interview with PSW #141 they identified that they asked the resident if the identified intervention was required and they indicated that it was not. In an interview with PSW #120, they identified that they checked the resident and the identified intervention was not required.

In an interview with Director of Nursing (DON) #101 on an identified date, they acknowledged that as per the Inspector's observations and interviews with the identified PSWs, the care set out in the plan of care related to toileting was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that care set out to manage resident #041's responsive behaviours, was provided as specified in their plan.

On an identified date, resident #041 demonstrated a physical responsive behaviour towards resident #031, causing an injury to resident #031.

On an identified date, the physician ordered an identified intervention for resident #041 which was to be implemented at an identified time for an identified time period. In an interview with DON #101 and #105 it was shared the home increased the identified intervention on an identified date.

Invoice records were reviewed from an identified time period. It was documented that the identified intervention was not provided on two identified dates.

In an interview with PSWs working on resident #041's home area it was shared that they monitored resident #041 when the identified intervention was not in place but did not provide the identified intervention. In an interview with the Administrator it was shared the home did not have a process in place for when the identified intervention for resident #041 could not be implemented.

In an interview with DON #101 and #105 it was confirmed that the identified strategy developed to manage resident #041's responsive behaviours was not always implemented as specified in their plan. (583) [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there is minimal risk to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
• compliance order (CO) #004 served on November 13, 2018 (2018_695156_0007) (683)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_743536_0006, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Protect resident #031 and all other residents from abuse by resident #041 or any other resident.

2. Revise and implement policy #AM-02-01-08, titled "Zero Tolerance of Abuse and Neglect" to include:
i) procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected,
ii) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents

3. Provide training/education to all direct care staff and management that includes the application and implementation of the revised policy. Attendance records and training content are to be maintained related to this training.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2018_743536_0006 issued on September 11, 2018, with a compliance date of October 31, 2018.

The licensee was ordered to comply with the Long-Term Care Homes Act (LTCHA) s. 19 (1).

Specifically, the licensee was ordered to:

(a) Ensure all residents are protected from abuse by residents #002 and #012.

(b) Ensure that resident #011 and all residents are protected from abuse and neglect by
the licensee or staff.

The licensee complied with steps (a) and (b).
The licensee failed to comply with s. 19 (1).

The licensee failed to ensure resident #031 was protected from abuse by resident #041 related to CIS #2931-000014-19 / CIS #2931-000015-19 / CI log #008611-19.

For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

Resident #041's plan of care was reviewed and it was noted that resident #041 had a history of identified behaviours towards staff and other residents and their care plan identified specific triggers for their behaviours and included specific interventions to respond to their behaviours.

On an identified date, it was identified during the home's investigation that resident #041 demonstrated specific behaviours so staff implemented an intervention from their plan of care. Shortly after this at an identified time, a physical altercation occurred between resident #041 and resident #031 which resulted in an injury to resident #031.

In an interview with the Administrator and DON #101 and #105 it was confirmed that resident #031 was not protected from physical abuse. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of

three residents reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
• compliance order (CO) #001 served on September 11, 2018 (2018_743536_0006)

(583)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

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 : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_743536_0006, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23 (1) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that every alleged, suspected or witnessed incident of abuse and neglect reported to the licensee are immediately investigated and appropriate action is taken in response to every such incident. The plan must include, but is not limited, to the following:

1. Ensure that all alleged, suspected or witnessed incidents of abuse and neglect involving resident #041 and all other residents that is reported to the licensee is immediately investigated and appropriate action taken in response to every such incident.

2. A revision of the policy #AM-02-01-08, titled "Zero Tolerance of Abuse and Neglect." The policy revision is to outline internal procedures and provide clear direction to direct care staff and management related to:
i. The immediate investigation of an alleged, suspected or witnessed incident of abuse and neglect.
ii. The appropriate action required to protect residents in response to the different types of abuse (emotional, financial, physical, sexual, verbal) including the identification of incidents that require police notification.

3. A plan to develop an ongoing auditing process at a frequency and schedule as determined by the licensee; to ensure that every incident of abuse and neglect is immediately investigated and appropriate action to protect residents is taken in every incident.
i. Include who will be responsible for doing the audits and evaluating the results.
ii. Audit records and documentation are to be retained by the home.

Please submit the written plan for achieving compliance for inspection 2019_661683_0008 to Lisa Bos, LTC Homes Inspector, MOHLTC, by email to SAO.generalemail@ontario.ca by July 30, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #002 from inspection #2018_743536_0006 issued on September 11, 2018, with

a compliance due date of October 31, 2018.

The licensee was ordered to:

(a) Ensure charge staff and management staff receive training on recognition of abuse
and neglect.
(b) Ensure that all alleged, suspected or witnessed incidents of abuse and neglect
reported to the licensee are immediately investigated and appropriate action taken in
response to every such incident.
(c) Ensure staff responsible for initiating the investigation have authority to take immediate
action to protect residents.
(d) Ensure those investigating alleged abuse have received training on conducting an
investigation.

The licensee completed steps (a) and (d).
The licensee failed to complete steps (b) and (c).

The licensee failed to ensure the witnessed incident of abuse of a resident by resident #041 that was reported to the licensee was immediately investigated and appropriate action was taken in response to the incident.

On an identified date, at an identified time, an altercation was observed by staff between resident #041 and resident #031, which resulted in an identified injury to resident #031.

Resident #041 had identified responsive behaviours that had been previously demonstrated towards other residents and staff. It was documented the RN notified the DON of the altercation. Registered nursing staff notified the Power of Attorneys (POA's) and physician, and assessed the residents and provided medical interventions at the time of the incident.

The home's investigation package provided by DON #101 contained the CIS

investigation which was submitted on an identified date, and a documented statement completed by PSW #165 on an identified date, of what occurred at the time of the incident.

In an interview with DON #101 and #105, Inspector #583 asked them to provide any evidence or information that identified what interventions were put in place to monitor resident #041 or what was done to ensure other residents on resident #041's home area were not at risk of harm for the first 24 hours after the incident occurred. No information was provided.

Resident #041's clinical record identified that the physician ordered an identified intervention on an identified date, and that the home implemented the identified intervention and a second intervention on an identified date, at an identified time, approximately 24 hours after the incident occurred.

In an interview with the Administrator it was confirmed that the incident was reported to management and that an immediate investigation was not initiated. It was confirmed that appropriate action to monitor and ensure the safety of residents at risk of harm on resident #041's home area were not immediately implemented. [s. 23. (1)]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
• compliance order (CO) #002 served on September 11, 2018 (2018_743536_0006)
(583)

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

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 : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

The licensee must be compliant with s. 84 of the Long-Term Care Homes Act 2007.

The licensee shall prepare, submit and implement a plan a to ensure the development and implementation of a continuous quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodations, care, services, programs and goods provided to residents. The plan must include, but is not limited to, the following:

1. A plan and schedule for the implementation of a training program for all management staff who are responsible for the development, implementation and monitoring of continuous quality activities and processes. Records of the training provided and attendance are to be maintained in the home.

2. A plan and schedule of activities that will result in the development and implementation of an organized continuous quality improvement and utilization system that includes, but is not limited to;
-quality improvement activities related to identified areas of non-compliance with the Long-Term Care Homes Act 2007 and Ontario Regulation 79/10,
-activities to monitor and evaluate the Orientation and Training Program,
-activities to ensure that all staff have access to current/updated licensee's policies and procedures,
-activities implemented to ensure completion of annual evaluations of the effectiveness and improvements made related to the licensee's policy to promote zero tolerance of abuse and neglect of residents, complaint management, staffing plan, continence and bowel management program as well as the falls prevention and management program.
Documentation of the above noted plan and documented activities shall be maintained by the home.

Please submit the written plan for achieving compliance for inspection 2019_661683_0008 to Lisa Bos, LTC Homes Inspector, MOHLTC, by email to SAO.generalemail@ontario.ca by July 30, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to develop and implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of accommodations, care, services, programs and goods provided to residents of the long-term care home.

While completing concurrent Complaint, Critical Incident System and Follow Up inspections it was noted that the long-term care home (LTCH) had not focused on a number of quality monitoring and improvement activities.

A) The Administrator was asked to provide the licensee's Quality Program guidance document(s) and in response provided the document #AM-06-02-02, titled "CQI Policy," which was part of the Administration Manual.

This document identified the following:
Statements
-The Continuous Quality Improvement (CQI) Program shall ensure all programs, services and activities of the Manor are continually monitored, audited and evaluated in order to continually improve quality of care.
-The CQI Program shall identify and reduce risks and increase safety of the environment for residents, staff and members of the public.
-The CQI Program shall provide assurance to the staff and public that the quality of programs and services is being continually monitored and deficiencies identified and corrected.

Staff Responsibilities
-The Administrator has overall responsibility for the development and implementation of the multidisciplinary Continuous Quality Improvement Process.
-Under the direction of the Administrator each Department Head will be responsible for the development and implementation of a Continuous Quality Improvement Process within their own department. Each department will participate in the multidisciplinary team activities of the CQI process.

Monitoring Activities
-The Management team is responsible for the co-ordination and monitoring of the Continuous Quality Improvement Process, and has the responsibility and authority to inquire into problems and implement solutions, and to continually

review CQI activities in each department and service provider and recommend changes if necessary.
-QI reports will be submitted to the Administrator on a quarterly basis for review and follow-up. On a quarterly basis a full CQI report will be prepared for the Quality Committee of the Board of Directors.

Department Participation Strategy:
-In conjunction with members of staff, each Department Head shall prepare and submit a monthly CQI report to the Management Team and the Professional Advisory Committee for review and follow up. The report will be reviewed with staff and posted in each department.

During discussions with DON #101 and DON #105, staff #166, staff #113 and staff #167, who were identified as Department Heads/Managers, they confirmed that they had not developed or implemented a Continuous Quality Improvement Process within their respective departments and had not participated in multidisciplinary team activities related to a CQI process prior to this inspection. During these discussions the Department Heads/Managers acknowledged they lacked a clear understanding of how to initiate a Continuous Quality Improvement Process within their department.

During discussions with the Administrator on an identified date, they verified/acknowledged/confirmed the following:
-They acknowledged the home had not completed any quality activities last year,

-They verified that Department Managers had not developed or implemented their individual department quality programs,
-They confirmed a multidisciplinary CQI process had not been developed or implemented,
-They acknowledged the Management Team had not fulfilled their responsibility to co-ordinate and monitor a CQI program,
-They acknowledged that the heads of the above noted departments lacked a clear understanding of how to develop a continuous quality program.
-They confirmed that a CQI report, that represented the quality activities in the home had not been prepared for the Quality Committee of the Board of Directors,
-They confirmed they had not co-ordinated strategic planning to identify goals,

objectives, plans or auditing activities related to any CQI process prior to this inspection, and
-They confirmed they had not completed other CQI activities identified in the licensee's policy such as the implementation of a performance appraisal program to review the performance of staff and service providers.

B) At the completion of the Complaint, Critical Incident System and Follow Up inspections, it was noted that staff in the home had not been successful in completing a number of required activities to monitor, analyze, evaluate and improve the quality of the accommodation, care, services, programs and goods provided to residents, specifically, the following:

i) Staff had not been successful in monitoring and improving the quality of care and services when it was identified that six of the nine compliance orders that had been previously served to the licensee and were followed up at the time of these inspections, had not been returned to compliance with respect to the requirements identified in the Long-Term Care Homes Act 2007 and Ontario Regulation 79/10.

ii) Staff had not monitored or evaluated staff training requirements when it was identified that staff had not received training required in the Long-Term Care Homes Act 2007, and Ontario Regulation 79/10, in an identified number of areas that were identified as mandatory training requirements and staff had not completed an analysis, evaluation or plan to improve the orientation and training program, when they did not complete an annual evaluation or update the training and orientation program, as was required.

iii) Staff had not ensured the licensee's policies and procedures were evaluated and updated to ensure those documents provided clear directions to staff who provide care to the residents. The Administrator confirmed that the most current policies and procedures were located in the computerized repository.

At the time of this inspection the following registered staff confirmed to Inspector #129 and Inspector #583 that they did not have access to current policies and procedures in the computerized repository: RPN #114, RPN #125, RPN #142, RPN #116, RPN #107 and RN #118.

iv) Staff had not completed annual evaluations or updated the following programs/areas as was required: Abuse Prevention, Management of Complaints, Staffing Plan, Continence and Bowel Management Program, Management of Responsive Behaviours, as well as the Falls Prevention program.

The Administrator, Department Managers, registered staff, records and documents provided by the home as well as the outcome of concurrently inspected Complaint, Critical Incident System and Follow Up inspections confirmed that the licensee did not ensure they developed and implemented a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents. [s. 84.]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it represents a systemic failure that has the potential to affect a large number of the LTCH's residents. The home had a level 2 compliance history as they had previous non-compliance to a different subsection. (129)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2019

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)

Linked to Existing Order / Lien vers ordre existant: 2018_695156_0007, CO #003;

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 must be compliant with s. 8 (1) of Ontario Regulation 79/10.

Specifically, the licensee must:

1. Complete and document Head Injury Routine (HIR) assessments for every unwitnessed fall as per the home's policies #RC-11-01-05 titled "Post Fall Assessment and Management," and #RC-10-01-07, titled "Head Injury Routine," for resident #003, #017 and all other residents requiring HIR assessments.

2. Complete and document fall risk assessments for resident #003 and all other residents as per the home's policy #RC-11-01-02, titled "Falls Prevention and Management Program: The Interdisciplinary Team Roles and Responsibilities."

3. Complete training for all registered staff regarding HIR and fall risk assessments including the frequency that the assessments are to be completed. The home is to maintain documentation of who completed the training, when the training was completed and the material covered in the training.

4. Ensure that a referral is sent to the RD when resident #005 or any other resident consumes a specified amount of their meals in three or more days, as per the policy #RC-08-02, titled "Hydration Monitoring."

5. Develop and implement an audit, at a frequency and schedule as determined by the licensee, to ensure that HIR and fall risk assessments are completed as per the home's policies. Audit records and documentation are to be maintained by the home.

6. Develop and implement an audit, at a frequency and schedule as determined by the licensee, to ensure that a referral is sent to the RD when residents consume a specified amount of their meals in three or more days. Audit records and documentation are to be maintained by the home.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO#003 from inspection #2018_695156_0007 issued on November 13, 2018, with a compliance date of December 31, 2018.

The licensee was ordered to be complaint with s. 8 (1) of Ontario Regulation 79/10.
Specifically, the licensee was ordered to ensure that they complied with the licensee's policies: Falls Prevention and Management Program: Post Fall Assessment and Management RC-11-01-05" and "Emergency and Incident Procedures, Head Injury Routine RC-10-01-07." The policies identified that registered nursing staff were to initiate the Head Injury Routine (HIR) for all unwitnessed falls and falls that resulted in a possible head injury or when the resident was receiving anticoagulant therapy; staff were directed to monitor every hour for the first four hours, and then every four hours for 24 hours post fall for signs of neurological changes ie: include facial droop, behaviour change or weakness affecting one side of the body.

The licensee failed to complete all steps in CO #003.

The licensee failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention and management program that provided strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policies #RC-10-01-07, titled "Head Injury Routine," #RC-11-01-05, titled "Post Fall Assessment and Management," and #RC-11-01-02, titled "Falls Prevention and Management Program: The Interdisciplinary Team Roles and Responsibilities," which were part of the licensee's Falls Prevention and Management Program. Policy #RC-11-01-05 indicated that registered nursing staff were to initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that resulted in a confirmed or possible head injury. The HIR policy, #RC-10-01-07, indicated the frequency to monitor residents was every 30 minutes for one hour, if stable then every hour for the next three hours and if stable, every four hours for 48 hours. In addition, the policy outlined that staff were to: assess resident's pupils, note if they're more difficult to rouse than usual, any nausea and/or vomiting, if the resident was confused or more confused than usual, any headache that gets

worse, any unusual twitching of arms or legs, unusual appetite, any actions felt to be bizarre or strange, any unusual drowsiness, and all findings were to be documented on the Neurovitals Record. Policy # RC-11-01-02 identified under RPN tasks, that staff were to update the fall risk assessment tools when completing the quarterly assessments and to update care plans as necessary.

A) A review of CI log #008278-19 / CIS #2931-000013-19, indicated that on an identified date, resident #003 sustained an unwitnessed fall in their room at an identified time. The resident was sent to hospital on an identified date, and they sustained an identified injury.

The written plan of care was reviewed and found resident #003 had a fall resulting in an injury on an identified date, and an identified number of unwitnessed falls on identified dates.

i) Resident #003's clinical record was reviewed and Neurological Flow Sheets (NFS) from identified dates were obtained for resident #003's identified falls. A review of the NFS identified that the assessments were not completed as per the outlined frequency.

In an interview with DON #101 on an identified date, they confirmed that the above noted policy was in place at the time of the identified falls for resident #003. DON #101 acknowledged that registered staff were expected to complete the HIR at the directed frequency. DON #101 acknowledged that the Neurological Flow Sheet had been recently updated and staff were not provided training. Inspector #750 reviewed the above noted NFS with DON #101 who confirmed that the assessments were not completed as per the policy.

The licensee failed to ensure that staff complied with the "Post fall Assessment and Management" and "Head Injury Routine" policies when completing the HIR assessments for resident #003 on the identified dates.

ii) A review of the written plan of care for resident #003 on an identified date indicated that two fall risk assessments were completed for this resident prior to their fall on an identified date. No further assessments were completed prior to the fall on the identified date, or immediately following.

In an interview with RPN #102 on an identified date, they acknowledged that fall risk assessments should be completed quarterly, when a resident falls and when a resident's status changes.

On an identified date, in an interview with DON #101, they confirmed that assessments, specifically fall risk assessments, were expected to be completed quarterly and with any change of status. Inspector #750 reviewed resident #003's fall risk assessment history with DON #101 on Point Click Care (PCC) and they acknowledged that the fall risk assessments were not completed at the identified intervals.

The licensee failed to ensure that staff complied with the "Falls Prevention and Management Program: The Interdisciplinary Team Roles and Responsibilities" policy when fall risk assessments were not completed at the identified intervals for resident #003.

B) A review of CI log #004001-19 / CIS #2931-000008-19 identified that resident #017 had an unwitnessed fall on an identified date, which resulted in an identified injury. A review of the CI and the resident's written plan of care identified that they also had unwitnessed falls on other identified dates.

The clinical record for resident #017 was reviewed on an identified date, and Neurological Assessment Records (NAR) were found for the identified falls. On an identified date, RPN #123 explained NARs were used to assess residents who fell and required head injury routine follow up. All of the identified assessments were not completed as per the determined frequency.

In an interview with DON #101 on an identified date, they confirmed that the two policies noted above were the policies in place at the time of resident #017's falls. DON #101 noted that staff were expected to complete the post fall head injury routine assessment at the outlined frequency in the policy. Inspector #750 reviewed the identified NARs with DON #101 and they acknowledged that staff had not completed them as indicated and did not follow the policy.

The licensee failed to ensure that staff complied with the "Post Fall Assessment and Management" and "Head Injury Routine" policies when completing the identified head injury routine assessments for resident #017. [s. 8. (1) (a),s. 8.

(1) (b)]

2. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10 s. 68 (2) (a) and in reference to LTCHA s. 11 (1), the licensee was required to have an organized program of nutrition care and dietary services and hydration that included the development and implementation of policies and procedures relating to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the licensee's policy #RC-08-02, titled "Hydration Monitoring," last revised on an identified date, which was part of the licensee's nutrition care and dietary services program. The "Hydration Monitoring" policy stated:

"Other indications for registered dietitian (RD) referrals: [a specified amount of] meals consumed in three or more days."

A complaint log #009642-18 was submitted to the Director on an identified date, related to the care of resident #005.

A review of the clinical record for resident #005 indicated that they were at an identified nutritional risk related to identified diagnoses. A review of the POC documentation "Percentage of meals consumed" indicated that on identified dates, resident #005 consumed a specified amount of their meals per day. Further review indicated that referrals to the RD related to the change in intake on the identified dates were missing.

During an interview on an identified date, RPN #107 stated that referrals to the RD were done electronically or verbally and were made when a resident's intake was a specified amount for two to three consecutive meals. RPN #107 also stated, following a review of the electronic record, that they did not see any RD

referrals sent electronically regarding the change in intake however, a referral could have been done verbally. During an interview on an identified date, the RD stated that they received referrals electronically however staff would also refer a resident verbally without any documentation. The RD also stated that if they received a referral verbally they would include that in their documentation. During an interview on an identified date, the DON #101, stated the expectation was for staff to initiate a RD referral when a resident consumed a specified amount of their meals. DON #101 could not provide any evidence that resident #005 was referred to the RD related to the identified dates.

The home did not ensure that a referral was sent to the RD when resident #005 consumed a specified amount of their meals in three or more days, as per their "Hydration Monitoring" policy. (682) [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
• compliance order (CO) #003 served on November 13, 2018 (2018_695156_0007)
• Voluntary plan of correction (VPC) issued April 12, 2017 (2017_57610a_0006) (750)

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

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 : 006

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

Linked to Existing Order / Lien vers ordre existant: 2018_743536_0006, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The licensee must be compliant with s. 76 of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that all staff at the home have received training as required by LTCHA 2007, c. 8, s. 76. The plan must include, but is not limited, to the following:

1. A plan and schedule of activities that will result in the development and implementation of the home's training and orientation program that includes, but is not limited to;

a) A designated lead for the training and orientation program.

b) A process on how training will be rolled out and implemented, including who will prepare the training content and who is responsible for teaching and/or assigning the training to staff. If different staff will be responsible for providing training in different areas, identify who will be responsible for what area of training.

c) How the home will ensure that training content meets the legislative requirements and aligns with the polices and procedures that are implemented in the home.

d) A process for how documentation will be maintained that includes who completed what training, when the training was completed, and the content in the training.

e) An auditing process to ensure that all staff receive the required training and

what action will be taken if it is not completed.

f) A process to ensure that the home is on track to complete all of the required training by the compliance due date.

2. Identify how the home will ensure that training is provided to all of the home's newly hired staff in relation to LTCHA s. 76 (2) 3, before performing their responsibilities
• The long-term care home's policy to promote zero tolerance of abuse and neglect of residents

3. Identify how the home will ensure that training is provided to all staff who work in the home pursuant to a contract or agreement between the licensee and an employment agency or other third party, in the areas identified below under LTCHA s. 76 (2), before performing their responsibilities:

• The Residents' Bill of Rights
• The long-term care hone's policy to promote zero tolerance of abuse and neglect of residents
• The duty under section 24 to make mandatory reports
• The protections afforded by section 26
• Fire prevention and safety
• Emergency and evacuation procedures
• Infection prevention and control

4. Identify how the home will ensure that all staff in the home are trained on:
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty under section 24 to make mandatory reports

5. Identify how the home will ensure that all staff who provide direct care to residents are trained on:
• Abuse Recognition and Prevention
• Mental Health Issues, including care for persons with dementia
• Behaviour Management
• Any other areas provided for in the regulations, including: falls prevention and management, skin and wound management, continence care and bowel management and pain management.

6. Identify how the home will ensure that all staff who apply physical devices or who monitor residents restrained by physical devices, are trained in the application, use and potential dangers of these physical devices.

Please submit the written plan for achieving compliance for inspection 2019_661683_0008 to Lisa Bos, LTC Homes Inspector, MOHLTC, by email to SAO.generalemail@ontario.ca by July 30, 2019. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #003 from inspection #2018_743536_0006 issued on September 11, 2018, with a compliance date of November 30, 2018.

The licensee was ordered to comply with the Long-Term Care Homes Act (LTCHA) s. 76 (4),
s. 76 (7) 1, 3

Specifically, the licensee was ordered to:

(a) Ensure that all staff in the home including agency staff if utilized have received training on the duty under section s. 24 to make mandatory reports; annually. The licensee must ensure that all staff in the home who provide direct care to residents have received training on behaviour management and abuse recognition and prevention annually.

(b) All staff will be trained on mandatory reporting by October 26, 2018.

(c) All staff who provide direct care to residents will be trained on behaviour management
and abuse recognition and prevention by October 26, 2018.

(d) A record will be kept of this training, including the person who is responsible for
providing the training, staff who participated. The record will identify the total number of all

staff in the home and a total number of all staff who provide direct care in the home.

(e) A record will be kept of the content of the training that was provided by the home.

The licensee completed step (e).
The licensee failed to complete steps (a), (b), (c) and (d) in CO #003.

In addition, the licensee has failed to comply with the following compliance order (CO) #002 from inspection #2018_695156_0007 issued on November 13, 2018, with a compliance date of December 31, 2018.

The licensee was ordered to comply with Ontario Regulation 79/10 s. 221 (1).

Specifically, the licensee was ordered to ensure that:

(a) All staff who had not received training as of January 1, 2018, including staff #109 and who provide direct care to residents will be trained on falls prevention management and pain management including pain recognition of specific and non-specific signs of pain.

(b) A record will be kept of this training, including the person who is responsible for providing the training, staff who participated. The record will identify the total number of all staff in the home and a total number of all staff who provide direct care in the home.

(c) A record will be kept of the content of the training that was provided by the home.

The licensee completed step (c).
The licensee failed to complete steps (a) and (b) in CO #002.

The licensee failed to ensure that all staff received training as required by this section.

The licensee failed to ensure that no person mentioned in subsection (1)

performed their responsibilities before they received training in the areas mentioned below.

In accordance with O. Reg 79/10 s. 222 (1) (a), a licensee of a long-term care home is exempt from the requirements under section 76 of the Act with respect to persons who fall under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act.

LTCHA, 2007, s. 2 (1) defines staff as persons who work in the home, (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

In accordance with O. Reg 79/10 s. 222 (2), the licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1 related to the Residents' Bill of Rights, paragraph 3 related to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, paragraph 4 related to the duty under section 24 to make mandatory reports, paragraph 5 related to the protections afforded by section 26, paragraph 7 related to fire prevention and safety, paragraph 8 related to emergency and evacuation procedures and paragraph 9 related to infection prevention and control of subsection 76 (2) of the Act before providing their services.

A) The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

In an interview with DON #101 on an identified date, they indicated that the home used an employment agency to fill PSW, RPN or RN positions when scheduled shifts could not be filled by the home's employees. The content of the orientation provided to agency PSWs, RPNs and RNs was reviewed which included two components: online training provided by the third party and an orientation completed in the home. Each were to be completed prior the staff being allowed to perform their responsibilities in the home.

The home's RN, RPN and PSW orientation checklists were reviewed which included direction on what training was required for orientation and had a trainer and staff sign off section that were to be initialed when completed. When

reviewed, no content was found related to the home's policy to promote zero tolerance of abuse and neglect.

Orientation training records were reviewed for three agency staff members that worked multiple shifts in 2019 in the home. It was confirmed with DON #101 that agency RPN #127, agency RN #128 and agency RPN #129 did not receive training on the home's policy to promote zero tolerance of abuse and neglect before performing their responsibilities.

In an interview with DON #101 it was confirmed that training related to the home's policy to promote zero tolerance of abuse and neglect was not included in the orientation training provided to agency staff. (583)

B) A review of CI log #008725-17 / CIS #2931-000009-17, which was submitted to the Director on an identified date, included allegations of staff to resident abuse by PSW #112 to resident #014.

In an interview with the Administrator on an identified date, they indicated that the home used a third party for PSWs who provided a specified intervention residents. In an interview with the Manager of Recreation and Volunteer Services on an identified date, they indicated that PSW #112 worked at the home, beginning on an identified date, through an identified employment agency to provide a specified intervention to resident #014. On an identified date, they acknowledged that the home and the identified employment agency did not have any training and orientation records for PSW #112, in any of the required areas.

The home did not ensure that orientation was provided as required for PSW #112 in the areas of the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded by section 26, fire prevention and safety, emergency and evacuation procedures and infection prevention and control prior to them providing services in the home. (683)

C) A review of CI log #000980-19/ CIS #2931000003-19, which was submitted to the Director on an identified date, included allegations of resident to resident abuse involving resident #025 and resident #030.

During an interview on an identified date, RPN #125 indicated that the home used a third party for PSWs who provided a specified intervention for resident #030. During an interview on an identified date, the Administrator identified that PSW #149 was scheduled on an identified date to provide the specified intervention for resident #030 related to responsive behaviours. A review of an identified invoice confirmed that PSW #149 worked at an identified time on an identified date. A review of the policy titled "Resident Approaches and Behaviours of Daily Living," from an identified date, stated;
"All staff, including contractors providing direct care and volunteers, will be oriented/trained prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behaviour management as per LTCHA 2007."

During an interview on an identified date, PSW #149 denied receiving any training or orientation on the required areas prior to commencing their work in the home. During an interview on an identified date, the Manager of Recreation and Volunteer Services stated that orientation training was not provided to PSW #149 prior to them commencing work in the home.

The home did not ensure that orientation was provided as required for PSW #149 in the areas of the Residents' Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded by section 26, fire prevention and safety, emergency and evacuation procedures and infection prevention and control prior to them providing services in the home. (682)

2. The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

The licensee failed to ensure that all staff in the home received training under s. 76 (2) 3, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and s. 76 (2) 4, the duty under section 24 to make mandatory reports at times and intervals provided for in the regulations. 2007, c.8, s. 76 (4)

In accordance with O. Reg. 79/10, s. 219 (1), the licensee was required to retrain all staff in the home annually for the purpose of s. 76 (4) of the Act.

A) Course completion and material content documents were reviewed titled "IWM Resident Abuse and Neglect.pdf." It was confirmed by the Manager of Recreation and Volunteer Services that all staff in the home were provided online access to complete this education which included the home's policy to promote zero tolerance of abuse and neglect of residents. As of an identified date, it was documented on the record that an identified number of staff did not complete the training.

In an interview with the Administrator on an identified date, it was confirmed that all staff in the home did not complete the required annual training on the home's policy to promote zero tolerance of abuse and neglect of residents in an identified year. (583)

B) Course completion and material content documents were reviewed for the following documents:
"Whistle Blowing Protection"
"Critical Incidents Part 1: Categories and Timelines for Reporting"
"Critical Incidents Part 2: Mandatory Reporting Responsibilities and Procedures by Surge Learning"
"Resident Abuse and Neglect"

In an interview with the Administrator on an identified date, it was confirmed that completion of the training noted above was the home's required annual training related to the duty under section 24 to make mandatory reports. It was confirmed that not all staff in the home completed this required training in an identified year.

The home had a compliance order (CO) issued during Inspection #2018_743536_0006 and the home was directed to ensure all staff in the home completed training on mandatory reporting by an identified date. In an interview with the Administrator on an identified date, it was confirmed that a significant number of staff completed this training in an identified month, after the compliance due date. (583)

3. The following non-compliance was identified in complaint inspection #2019_661683_0007, which was completed concurrently with this inspection.

The licensee failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, received training in 1. Abuse recognition and prevention, 2. Mental Health issues, including caring for persons with dementia, 3. Behaviour management and 6. Any other areas provided for in the regulations, at intervals provided for in the regulations.

In accordance with O. Reg. 79/10, s. 221 (2) 1, the licensee was required to retrain all direct care staff in the home annually. In accordance with O. Reg. 79/10, s. 221 (2) 2, the licensee did not assess the individual training needs of staff members as was confirmed by the Administrator during an interview.

A) The licensee failed to ensure that all staff who provided direct care to residents received training in 1. Abuse Recognition and Prevention.

Course completion records and material content records that were provided by the home were reviewed titled "Resident Abuse and Neglect." It was documented as of an identified date, an identified number of staff did not complete the training.

In an interview with the Administrator on an identified date, it was confirmed that this specific training module contained the education related to abuse recognition and prevention and that not all required direct care staff completed the required annual training.

B) The licensee failed to ensure that all staff who provided direct care to residents received training in 2. Mental Health Issues, including care for persons with Dementia and 3. Behaviour Management.

Course completion records and material content records provided by the home were reviewed for the following documents:
"Dementia Behaviour Management"
"Working with Dementia Part 2: How to approach residents"

In an interview with the Administrator on an identified date, it was confirmed that

these were the specific training modules that contained the education related to mental health issues, including care for persons with dementia and related to behaviour management. It was confirmed that all direct care staff did not complete the required training as of an identified date.

The home had a CO issued during Inspection #2018_743536_0006 and the home was directed to ensure all direct care staff in the home completed training by an identified date, on abuse recognition and prevention and behaviour management. In an interview with the Administrator on an identified date, it was confirmed that a significant number of staff completed this training in an identified month, after the compliance due date.

C) The licensee failed to ensure that all staff who provided direct care to residents received training in 6. Any other areas provided for in the regulations.

i) In accordance to O. Reg. 79/10, s. 221 (1) 1 and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training in the area of Falls Prevention and Management.

Course completion records and material content records that were provided by the home were reviewed titled "Falls Prevention Part 1: An introduction." It was documented as of an identified date, an identified number of direct care staff had not completed this training.

In addition, the home required all registered nursing staff to complete the following as part of the home required falls prevention and management training:
"Falls Prevention Part 2: Fall Risk Factors in Seniors"
"Falls Prevention Part 3: Assessment and Interdisciplinary Roles"
"Falls Prevention Part 4: Interventions in Minimizing Risk for Falls and Fall-Related Injuries"
It was documented that an identified number of registered nursing staff did not complete the above noted training in an identified year.

In an interview with the Administrator on an identified date, it was confirmed that all direct care staff did not complete annual training in Falls Prevention and Management in an identified year.

ii) In accordance to O. Reg. 79/10, s. 221 (1) 2 and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Management.

Course completion records and material content records that were provided by the home were reviewed titled, "Skin Care and Pressure Ulcers for Direct Care Staff" and it was documented that an identified number of PSWs did not complete the training for an identified year.

In an interview with the Administrator on an identified date, it was confirmed that RPNs and RNs had not been assigned any training to complete and that the home had not created Skin and Wound Management training for registered nursing staff to complete. It was confirmed that all direct care staff did not complete annual training in Skin and Wound Management in an identified year.

iii) The licensee failed to ensure that all staff who provided direct care to residents received training in 6. Any other areas provided for in the regulations.

In accordance to O. Reg. 79/10, s. 221 (1) 3, the home was required to provide all staff who provide direct care to residents with annual training in the area of continence care and bowel management.

Course completion records and material content records that were provided by the home were reviewed titled "Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) Continence Care and Bowel Management." It was documented as of an identified date, an identified number of direct care staff had not completed this training. Further record review included an email from an identified date, provided by DON #101 that stated that there were an identified number of direct care staff and that an identified number of direct care staff were not assigned to the OANHSS continence care and bowel management course.

In an interview on an identified date, DON #101 confirmed that all direct care staff did not complete annual training in continence care and bowel management in an identified year.

iv) In accordance to O. Reg. 79/10, s. 221 (1) 4. and 219 (1) the home was

required to provide all staff who provide direct care to residents with annual training in the area of Pain Management, including pain recognition of specific and non-specific signs of pain.

Course completion records and material content records that were provided by the home were reviewed titled, "Module 1 The Pain Experience: A Module for Direct Care Staff" and it was documented that an identified number of staff did not complete the training.

In an interview with the Administrator on an identified date, it was confirmed that all direct care staff did not complete annual training in pain recognition of specific and non-specific signs of pain.

v) In accordance to O. Reg. 79/10, s. 221 (1) 5 and 219 (1) the home was required to provide all staff who provide direct care to residents with annual training 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.

Course completion records and material content records that were provided by the home were reviewed titled, "Restraints and PASDs: A Module for Direct Care Staff in Long Term Care Ontario only (a presentation by surge learning)," and it was documented that an identified number of staff did not complete the training.

In an interview with the Manager of Programs, it was confirmed that all direct care staff who apply physical devices did not complete annual training, including the application of identified physical devices. (583) [s. 76.]

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to a pervasive deficiency in the long-term care home. The home had a level 5 compliance history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:
• compliance order (CO) #003 served on September 11, 2018 (2018_743536_0006)
(683)

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 : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

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

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

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 16th day of July, 2019

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Lisa Bos

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