Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2019	2019_752627_0016	009136-19, 011306-19, 011720-19, 014455-19, 014725-19	Complaint

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Leacock Care Centre
25 Museum Drive ORILLIA ON L3V 7T9

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

SYLVIE BYRNES (627), MICHELLE BERARDI (679), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 15-19, 22-26 and July 30 - August 8, 2019.

The following intakes were inspected during this Complaint inspection:

- One intake related to care concerns;
- One intake related to resident rights;
- One intake related to concerns regarding wound care; and,
- Two intakes related to alleged resident to resident abuse.

A Critical Incident System Inspection, #2019_752627_0017 and a Follow-Up Inspection #2019_752627_0015, were conducted concurrently with this inspection.

A Written Notification, Compliance Order and Director Referral related to section 6 (10) (b) of the Long-Term Care Homes Act, 2007, was identified in this inspection and has been issued in Follow Up Inspection Report #2019_752627_0015, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the previous Administrator, Director of Care (DOC), staff members, families and residents.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

13 WN(s)
4 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was submitted to the Director which indicated that resident #002 had developed a physical condition, which led to medical interventions. The complaint alleged that the physical condition kept worsening with no improvement, which negatively effected the resident's status and outcomes.

Inspector #638 reviewed resident #002's health care records and identified that the resident had an intervention in place, on a specific date. The physician's orders identified that the intervention was to be discontinued at a later specific date.

Inspector #638 reviewed the electronic medication administration record (eMAR), and identified a scheduled due date for discontinuation of the intervention. The Inspector reviewed the progress notes and identified that the intervention was not discontinued on the specified date, and that the Nurse Practitioner (NP) was unsure of what action to take and directed the staff member #118 to continue the intervention for a few more days. The Inspector was unable to identify any written orders related to the direction the NP provided in the progress notes.

Inspector #638 interviewed staff member #111. They indicated that they based care on the physicians' orders and that they were required to follow the orders, within reason, for resident care. The Inspector reviewed the eMAR task scheduled for a specific date, related to discontinuing the intervention, with the staff member. Staff member #111 stated that the task was clear and that it directed them to discontinue the intervention on a specific date but indicated that staff had not received education related to the specific intervention.

During an interview with Inspector #638, staff member #112 indicated that registered staff were expected to assess, manage and treat resident #002's physical condition. The Inspector reviewed the eMAR task regarding the specific intervention, with the staff member. The staff member indicated that it was clearly outlined that the intervention was to be discontinued on a specific date.

Inspector #638 interviewed staff member #114 who indicated that they had discontinued the specific intervention on a specific date; two days later than was indicated on the physician's order. The staff member indicated that there had been some confusion surrounding the specific intervention and that they sought direction from the NP. The NP directed the staff to continue the specific intervention for another day or two. Staff member #114 indicated that they had not believed the NP wrote an order for this direction and just verbalized this to the staff member. The Inspector reviewed the eMAR task with staff member #114 who indicated that they had not been aware that the order had been identified in the eMAR and that it was clear, based on the eMAR, that they were to discontinue the specific intervention on a specific date.

In an interview with Inspector #638, NP #121 indicated that staff member #118 contacted them on a specific date, related to resident #002's specific intervention. The NP indicated that they had instructed the staff member to continue the specific intervention, but were unsure if an order had been written. The NP indicated that they had not consulted the physician related to the intervention and were unsure when the specific intervention had first been administered; therefore, they directed staff to continue the specific intervention.

The Inspector reviewed the physician's orders again and was unable to identify any orders to continue with the specific intervention.

In an interview with Inspector #638, staff member #118 indicated that they were looking after resident #002 on a specified date. The staff member indicated that they were unsure when the specific intervention was to be discontinued, although the eMAR had directed them to discontinue the intervention on a specific day. The staff member indicated that they were unable to contact the physician to clarify the orders and that staff member #114 had directed them to inquire with the NP. The staff member indicated that the NP had provided verbal direction to continue the specific intervention, but they had not written an order and had written the direction in a progress note instead.

Inspector #638 reviewed the home's policy titled, "Resident Rights, Care and Services –

Plan of Care", last revised March 13, 2018, which indicated that registered staff were to ensure that care was provided to the residents as specified in the plan of care.

In an interview with Inspector #638, the Director of Care (DOC) indicated that treatment and direction related to the specific intervention was kept in the eMAR. Upon reviewing the direction for the specific intervention with the DOC, they indicated that the direction appeared clear, however, the staff member may have gone back and reviewed the physician's orders and became confused regarding the date to discontinue the specific intervention. The DOC and the Inspector reviewed the progress notes and identified the direction from the NP. The DOC indicated that they were unsure if the NP had the capacity to give this sort of direction and they were unsure if they had written an order or if it was only verbalized. Upon reviewing all the information, the DOC indicated that the staff member may have been afraid to discontinue the specific intervention and indicated that the specific intervention should have been discontinued, but due to the confusion surrounding the order, they followed the NP's direction. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Neglect is defined in the Ontario Regulation 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being,

and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) On a specific date and time, Inspector #638 observed staff member #106 and [staff member] #123 approach staff member #113 and inform them that resident #005 was exhibiting specific medical symptoms. Staff member #106 and [staff member] #123 reported to staff member #113 that the resident received a specific intervention when they exhibited specific medical symptoms. Staff member #113 stated, without assessing the resident or checking their plan of care, that they were not comfortable providing the specific intervention and would report resident #005's specific medical symptoms to the next shift. The Inspector noted that staff member #106 and [staff member] #123 re-iterated that the resident required the specific intervention for the medical symptoms.

A review of resident #005's care plan identified a goal, to reduce frequency of the above mentioned medical symptoms. Inspector #638 reviewed the medical orders for resident #005 and identified in the orders section on Point Click Care (PCC) that the resident was ordered a specific intervention when they demonstrated specific medical symptoms.

Inspector #638 interviewed [staff member] #123, who indicated that they informed staff member #113 of resident #005's specific medical symptoms, because they were normally given a specific intervention to help minimize the symptoms.

During an interview with staff member #113, when asked by the Inspector the status of resident #005, they indicated that they did not know the resident, but staff had just reported that the resident was having specific medical symptoms. Staff member #113 went on to state that they were "not comfortable administering [the specific intervention] to people they didn't know"; and they were "not sure of these residents". The Inspector inquired what action was taken when resident #005 was experiencing the above mentioned specific medical symptoms to which staff member #113 indicated that "a lot of people go straight to the specific medical intervention, but I don't". The Inspector followed up asking why [the specific intervention] was not provided to resident #005 as they were demonstrating the specific medical symptoms for which the specific intervention had been ordered for? Staff member #113 stated that they had "not assessed the resident [to determine their needs] and [they] did not know the resident at all and were not comfortable providing [the specific intervention] at this time". The staff member stated that they would report the specific medical symptoms to the next shift.

Inspector #638 interviewed staff member #114, at the beginning of the following shift

They indicated that they had been made aware of staff member #113's hesitance to provide resident #005 with the specific medical intervention, which was requested by [staff member] #123. Staff member #114 indicated that they believed staff member #113 was hesitant to provide the intervention, without checking. Staff member #114 stated to the Inspector that they informed staff member #113 to provide the intervention because resident #005 was exhibiting specific medical symptoms. Staff member #114 indicated that staff were expected to check the care plan if they were unsure of resident needs.

The Inspector sat near resident #005's room until approximately one hour and a half after staff member #113 had completed their shift. During the observation, the Inspector did not observe staff member #127 assess or inquire about the resident's well being, including if they were having specific medical symptoms. The Inspector had not observed staff member #113 assess nor write a progress note related to resident #005's condition prior to staff member #113 leaving. During an interview with the Inspector, staff member #127 indicated that staff member #113 reported that resident #005 had received another intervention; however, there was no mention of the resident's reported medical symptoms.

Inspector #638 followed up with the staff member #114. Staff member #114 indicated that they were expecting staff member #113 to provide resident #005 with the specific medical intervention and stated they heard staff member #127 state that both them and staff member #113 were going to check on the resident. The Inspector reviewed the documentation records with staff member #114, who indicated that staff member #113 should have documented on the resident's status, if they went down to see the resident. At that time, staff member #114 went and checked resident #005's status to ensure they were not in any distress.

The Inspector followed up on the following day and identified in resident #005's records that they had received the specific medical intervention, approximately three and a half hours after the medical symptoms were initially reported.

In an interview with Inspector #638, Physician Assistant (PA) #117 indicated that resident #005 was provided the specific medical intervention to manage specific medical symptoms. The PA indicated that they were not concerned with the interactions being provided along with a separate intervention since the resident "suffers quite a bit".

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019, defines neglect as the

failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In an interview with Inspector #638, the Co-Director of Care (Co-DOC) #128 indicated that the home defined neglect as a pattern of inaction toward resident care. Co-DOC #128 indicated that a staff member not knowing a resident was not an appropriate reason to not provide an intervention. Co-DOC #128 stated that staff can review the care plan, eMAR, progress notes or consult with someone to identify what is normal for the resident. The Inspector reviewed the combination of issues observed by the Inspector related to staff member #113; not reviewing resident #005's plan of care, not assessing the resident and not documenting what had been reported, not reporting the symptoms on shift report and not providing the intervention which managed resident #005's symptoms, with the Co-Doc #128. After review, the Inspector inquired if staff member #113 demonstrated a pattern of inaction in this instance, to which the Co-Doc of Care stated "yes". [s. 20. (1)]

2. Inspector #679 reviewed a concern/complaint form written by staff member #114. The description of the concern identified an incident where [staff member #144] reported witnessing [resident #013] was demonstrating a specific responsive behaviour towards [resident #018].

Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified that "the most Senior Administrative Personnel (or Charge Nurse if no manager in the home) who receives a report of resident abuse or neglect will: Assess the resident to determine any injury and provide any necessary care and ensure immediate support or assistance is provided to the resident who has been abused or neglected and assess the resident's condition, evaluating the safety, emotional and physical well-being.

A) Inspector #679 reviewed resident #018's electronic progress notes regarding the incident and could not identify any notes indicating that the resident was assessed or interviewed about the incident.

Inspector #679 interviewed staff member #114 who identified that they were notified of the incident involving resident #013 and resident #018 by a staff member on the unit. Inspector #679 questioned if resident #018 had been assessed after the incident, and

staff member #114 identified "No… looking back I should have talked to [them]".

B) Inspector #679 reviewed the home's policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019. The policy identified that staff were to commence a preliminary investigation by obtaining written and signed statements from all witnesses and documenting all pertinent information in the resident's record and complete resident incident reports.

Inspector #679 reviewed the electronic record and was unable to identify that a resident incident report was completed for this incident.

Together, Inspector #679, #627, and the DOC reviewed the electronic risk management section of PCC. The DOC identified that an incident report had not been completed.

C) Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified "Immediately notify the resident's substitute decision maker or any person specified by the resident of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. In all other cases, notification must be provided within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident".

During the interview with staff member #114, they identified that they were notified of the incident involving resident #013 and resident #018 by a staff member on the unit, on a specific date and time. Staff member #114 indicated to the Inspector that the day after the incident, they spoke to the resident and notified the substitute decision maker (SDM).

Inspector #679 reviewed resident #018's electronic progress notes and identified a note documented 19 hours after the incident which indicated that the writer had left a voice mail with [SDM] pending call back at this time.

Inspector #679 reviewed resident #013's electronic progress notes and identified a note, written by staff member #114 more than 18 hours after the incident, which identified that the SDM had been informed.

The previous Administrator was not available for an interview. [s. 20. (1)]

3. Ontario Regulation (O.Reg.) 79, of the Long-Term Care Home Act, 2007, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern or inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Director regarding the lack of treatment resident #004 had received in regard to a medical condition, which had led to a significant change in their health status. Please see WN #6, item #1, for further details.

Inspector #627 interviewed the complainant who stated that resident #004 was admitted to the home on a specific date and within a specific time frame, had a significant change in their health status.

Inspector #627 reviewed resident #004's medical health care records and noted resident #004 had a specific type of assessment completed upon their admission, for a medical condition they were admitted with. The Inspector was unable to locate any further assessments of resident #004's medical condition. The Inspector also identified, in the "vitals tab" in PCC that the resident had an abnormal vital sign since their admission, for a period of three days, at which time, the monitoring of the resident's abnormal vital sign was discontinued. The Inspector could not identify any other documented vital sign until a specific number of days later.

A further review of resident #004's progress notes, by Inspector #627, during the review period established a timeline of the resident's progressive deterioration.

Inspector #627 reviewed the home's policy titled, "Resident Rights, Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019, which defined neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the heath, safety or well-being of one or more residents".

Inspector #627 interviewed staff member #110 who stated that when a resident was admitted, they received a complete head to toe assessment and their vital signs were monitored for three days to establish a baseline. If the resident presented with abnormal vital signs, then the resident's vital signs would be monitored for a longer period of time,

until the vital signs were within the normal range. Staff member #110 further stated that if a resident had a specific medical condition, a specific assessment would be completed. Staff member #110 stated that if a resident with a specific medical condition developed a specific abnormal vital sign, they would notify the physician immediately, whereby they may be ordered a specific medical intervention. They stated that if they were unsure who the resident's physician was, they would notify the Co-Doc.

Inspector #627 interviewed staff member #113 who itemized specific signs and symptoms which would identify that the resident's condition was deteriorating, and that the physician should have been called when the resident exhibited the signs and symptoms. Inspector #627 and staff member #113 reviewed resident #004's health care records and noted that staff member #113 had documented that the resident had abnormal vital signs on their admission day. Staff member #113 stated they had made staff member #129 aware, although they had not documented the reporting. Staff member #113 also stated that they had discussed the resident with the Co-DOC, however, they had not reported the abnormal vital signs to a physician, the PA or the NP.

Inspector #627 interviewed staff member #129, who stated that they had assisted staff member #130 with resident #004's admission. Staff member #129 stated that they had not been made aware that the resident had developed abnormal vital signs. Staff member #129 stated that the first time they had been made aware of the abnormal vital signs, they had asked staff member #119 to reach out to Physician #131. They further stated that any abnormal vital signs would have been documented on the shift report to make the DOC and the following shift aware, to ensure that the resident was monitored for further abnormal signs. Staff member #129 stated that they had not made Physicians #131 and #132, the PA or the NP aware of the resident's abnormal vital signs.

Inspector #627 interviewed staff member #119 who stated that their only involvement with resident #004 was on the day of their admission and that they had called Physician #131 for admission orders only. They further stated that they had only been helping and not assigned to the unit, and only assisted with obtaining admission orders for resident #004, and that they had not been in contact with any other physician, the PA, or the NP.

Inspector #627 interviewed staff member #127 who stated that when resident #004 had developed abnormal vital signs, they had reported it to the oncoming shift, but had not reported to a physician, or the Co-DOC. They stated that on a specific date, seven days after the resident's admission, they had posted a message on the communicator to

advise Physician #132 and the PA, that the resident's condition had deteriorated. Staff member #127 stated that they had written that the resident's specific vital sign "remained within the norm", to indicate that the vital sign was normal at this time, although it had been abnormal upon admission and for the following two days after the admission when the resident's vital signs were monitored, as they thought that the abnormal findings were due to a different medical condition.

Inspector #627 interviewed the PA who stated that they were made aware that resident #004's care was transferred to Physician #132 on the day prior to the resident being transferred to the hospital. The PA stated that they were unfamiliar with the resident when they reviewed staff member #127's message on the communicator. The PA further stated that emergencies were not communicated on the communicator; the physician was called for anything urgent. The PA further stated that they had not been made aware of the resident's other abnormal vital signs, or they would have ordered specific interventions immediately.

Inspector #627 interviewed Physician #131 who stated that the home had contacted them three days after resident #004 was admitted to the home, for admission orders, at which time, they had informed the home that they were transferring the care of resident #004 to Physician #132. Physician #131 stated that they had not been made aware at any time that the resident's abnormal vital sings, or they would have instructed the staff member to make Physician #132 aware right away.

Inspector #627 interviewed Physician #132 who stated they had not had the opportunity to meet with resident #004. Physician #132 stated that the staff could have called them if they had concerns regarding the resident, as they were the Medical Director, and a physician was on call during off hours (evening, night and weekends). After reviewing resident #004's abnormal vital signs and symptoms, Physician #132 stated that the resident should have been sent to the hospital.

Inspector #627 interviewed staff member #128 who stated that every morning, management read the 24-hour shift report and discussed concerns at this time. Staff member #128 stated that if a resident developed abnormal vital signs, staff members should continue to assess the resident's vital signs and notify a physician as this would indicate that something was going on.

Inspector #627 interviewed the DOC who stated that if resident developed a specific abnormal vital sign, the nurse should have completed and documented an assessment.

The DOC stated that if the abnormal vital sign remained after a specific intervention, the physician should be called, the oncoming shift should be made aware, as well as management on the floor. They stated that if the staff were unsure of what to do, they could reach out to management for advice. The DOC stated that staff should have kept monitoring the resident's vitals past the mandatory three days after their admission and this had not been done.

The previous Administrator was not available for an interview. [s. 20. (1)]

4. A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse. Please see WN #6, item #2, for further details.

Inspector #638 reviewed resident #011's progress notes and identified a late entry created six days after the incident which described how a staff member had reported they had witnessed a responsive behaviour resident #012 had exhibited toward resident #011. The notation indicated that the Co-DOC had given directions to be followed to assist them in determining if they needed to report to MOH and the police.

The Inspector noted that there was no indication in the investigation or progress notes, that anyone had interviewed the residents, related to the incident. The progress note created five days after the incident outlined that staff member #116 met with resident #011. Staff member #116 asked the resident how they felt at the time of the incident, resident #011 responded negatively, and communicated what had ensued during the incident.

Inspector #638 and Inspector #627 interviewed staff member #128 who indicated that they had directed staff member #119 and staff member #129 to interview resident #011. Staff member #128 also indicated they had directed staff members #119 and #129 to call back with a follow up on the incident. The Inspectors inquired if any staff members had called them back to report the outcome of this concern. Staff member #128 indicated that staff member #119 and #129 had not called them back and they had followed up with the staff members two days after the incident.

In a subsequent interview staff member #128 indicated that they had formally interviewed resident #011 for the first time five days after the incident, after Inspector #627 had met with the resident. Staff member #128 indicated that resident #011 had negative feelings regarding the incident. Staff member #128 stated that they spoke to Ontario Provincial Police to report the incident, five days after the incident had occurred. Staff member #128

also stated that no staff were interviewed on the date of the incident and they had difficulties getting a hold of the staff member who had witnessed the incident and obtained their account of the incident, four days after the incident.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019, indicated that the Administrator or Director of Care or the Manager On-Call will interview the resident, other residents and any other person who may have any knowledge of the situation.

During an interview with the previous Administrator, the Inspectors inquired if anyone had interviewed the resident at the time of the incident, or any time prior to the follow up interview they conducted, after Inspector #627 had brought these concerns forward, five days after the incident. The previous Administrator was unsure and indicated they would need the weekend to determine if staff member #119 had interviewed resident #011 or if they just observed the resident's status on the day of the incident. There were no records provided to the Inspectors to support that any interview had occurred with the resident until five days after the incident.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Inspector #627 reviewed a memorandum, "Reporting Requirements Under the Long-Term Care Homes Act, OLTCA Conference", dated November14, 2018, sent by the Director to the Long-Term Care Homes Licensee and Administrators, and posted on the Long-Term Care Homes online Portal, reporting site, which indicated that: "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. 2) Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident".

A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse by resident #012 to resident #011. Please refer to WN #2, item #4 and WN #6, item #2, for further information.

Inspector #627 interviewed the complainant, who was resident #011's enacted SDM. The complainant stated that they had received a telephone call from an RN, who had informed them that a resident had demonstrated responsive behaviours towards resident #011, and that they (the RN) would be reporting the incident to the Co-DOC. The

complainant stated that they had called early one morning, and at the end of the day when their call had not been returned, at which time they reached the Co-DOC. The complainant stated that they had been told by the Co-DOC that they had not interviewed resident #011 or called the police as the resident had "seemed fine". When the complainant inquired as to why the home's abuse policy was not being followed, the Co-DOC had told them (complainant) that the information given in the admission package was not the process that was followed in the home as they had a new internal process that the home followed. The complainant stated that they had asked for a report of the investigation when it was completed and had been told that they (Co-DOC) were not required to do this, however, they (Co-DOC) would call them in four days. The complainant told Inspector #627 that they had felt that the home was minimizing the incident, the home refused to call the police and that they feared for resident #011's safety.

Inspector #627 interviewed resident #011, five days after the incident. During the interview, resident #011 communicated to the Inspector what had occurred during the incident and that they remained fearful this could occur again.

Inspector #638 and Inspector #627 reviewed the Ministry of Long-Term Care's online Critical Incident System (CIS) reporting portal and were unable to identify that a CIS report had been submitted for this allegation of resident to resident abuse.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019, indicated that suspected and or confirmed allegations of abuse shall be reported immediately as described in the following procedure; During business hours, notify the Ministry of Health and Long-Term Care immediately by way of the Critical Incident System (CIS) report.

Inspector #638 and Inspector #627 interviewed staff member #128 who indicated that immediate reporting was required when there was knowledge of suspicion of abuse. They indicated they had a hard time figuring out what happened as staff member #119 and #129 failed to call them back as requested.

During an interview with Inspector #638, the DOC indicated that abuse was immediately reported. They indicated staff would generally find out basic information surrounding the incident, which "shouldn't take much" and then report to the Ministry. Inspector #627 inquired if this incident should have been immediately reported, the DOC indicated that they should have reported the suspicion to the Ministry.

Inspector #638 and Inspector #627 interviewed the previous Administrator. They indicated that they followed the Ministry abuse decision tree and although the requirement was to immediately report, they do not report until they reached that part on the decision tree that directed them to report. Therefore, they only reported the incident once they were one hundred per cent sure the incident was abuse, which they had only determined five days after the incident, at which time they had reported the incident to the Director. [s. 24. (1)]

2. Inspector #679 reviewed a concern/complaint form written by staff member #114. The description of the concern identified that [staff member #144] reported witnessing [resident #013] demonstrating responsive behaviours towards resident #018. Please see WN #2, item #2, for further details.

Inspector #679 reviewed the Ministry of Long-Term Care's online CIS reporting portal and was unable to identify that a CIS report was submitted for this allegation of resident to resident abuse.

Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified: 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 Ministry of Health and Long Term Care: 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.

Inspector #679 reviewed a copy of the [Licensee Reporting of Abuse] decision tree which was attached to the concern/complaint form. The decision tree had a hand-written note at the top which identified that the incident was not abuse, due to resident #018's behaviour after the incident.

In an interview with Inspector #679, staff member #144 described the responsive behaviour that resident #013 had demonstrated toward resident #018. Staff member #144 identified that looking back on the incident, they considered it abuse.

In an interview with Inspector #679 and #627, staff member #114 identified that they were made aware of the incident by the staff member who was working on the unit. Staff member #114 identified that staff member #144 observed resident #013 demonstrating

responsive behaviours towards resident #018. Staff member #114 identified that the previous Administrator had directed them to write that resident #018 was not demonstrating negative emotions. Staff member #114 identified that they had a suspicion that this was abuse and that they felt this should have been reported; however, as per the direction given from the management of the home, it was not reported.

Inspector #679 and #627 interviewed the DOC who identified that when an allegation of abuse was brought forward to the home, they would follow the decision tree and discuss the incident as a team prior to reporting it to the Director. The DOC confirmed that a report was not submitted to the Director regarding this incident because it was discussed that it was not abuse.

The previous Administrator was not available for an interview. [s. 24. (1)]

3. Inspector #627 reviewed investigation notes for alleged abuse by resident #013 to resident #017, which was observed by staff member #136. In a written statement, staff member #136 described that they had witnessed resident #013 demonstrating responsive behaviours to resident #017.

Inspector #627 reviewed the Ministry of Long-Term Care's online CIS reporting portal and was unable to identify that a CIS report was submitted for this allegation of resident to resident abuse.

Inspector #627 reviewed the home's policy titled, "Resident Rights, Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified: 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 Ministry of Health and Long Term Care: 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.

Inspector #679 reviewed a copy of the [Licensee Reporting of Abuse] decision tree, which was attached to the concern/complaint form. The decision tree had a hand-written note at the top which identified, that [the responsive behaviour had been interrupted, therefore, it was not abuse].

In an interview with Inspector #679 and #627, staff member #114 identified that they were made aware of the incident by staff member #136, who was working on the unit,

however, they had been advised that the DOC was taking over the investigation. Staff member #114 indicated that according to the home's abuse policy, this was abuse.

Inspector #627 interviewed the DOC who stated that they had been made aware of the incident when they had received a report from staff member #136 and believed staff member #114 had been made aware as well. The DOC acknowledged that according to the home's abuse policy, the incident was abuse. The DOC stated that they had followed the decision tree, and along with the Administrator (Administrator at the time of the inspection), they had decided this was not reportable.

The previous Administrator was not available for an interview. [s. 24. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity,

including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the Director where they indicated that resident #002 had altered skin integrity. The complaint alleged that the resident's altered skin integrity kept worsening with no improvement, which negatively effected the resident's status and outcomes.

Inspector #638 reviewed resident #002's health care records and identified in a progress note that the resident's SDM made staff aware of a new area of potential altered skin integrity. The progress note further indicated that if they could not come to assess and that the the following shift would assess. The Inspector was unable to identify any notes or assessments on the resident's new area of altered skin integrity until four days later where it was identified that the area had worsened from the description provided by resident #002's SDM.

In an interview with Inspector #638, staff member #106 indicated that they monitored resident skin integrity during care giving periods and documented their findings in Point of Care (POC). Staff member #106 stated that if they identified a new area of altered skin integrity they would notify registered staff who would complete required assessments and treatment interventions.

During an interview with Inspector #638, staff member #111 indicated that whenever they were made aware of a new area of altered skin integrity, the area was to be assessed and treatment determined the day it was identified. The Inspector reviewed the date of identification and the date of the initial assessment with staff member #111, who indicated that they should have assessed and initiated interventions the day it was identified, instead of four days later.

Inspector #638 interviewed staff member #114 who indicated that resident #002 was identified as having a new area of altered skin integrity, after a review of the progress notes. Staff member #114 then identified that the initial assessment had occurred four days after the SDM had reported an area of altered skin integrity, and stated that staff should have done the assessment when it was first reported to them. The staff member indicated that this was important because once the assessment was completed staff would include interventions in the plan of care to manage the new area of altered skin integrity.

The home's policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program" last revised October 17, 2018, indicated that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds; received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required.

In an interview with Inspector #638, the DOC indicated that whenever a new area of altered skin integrity presented, registered staff would assess the area and implement wound treatment and interventions to promote healing. The Inspector reviewed resident #002's progress notes and assessments with the DOC who indicated that it did not appear as though any assessment or intervention was done until four days after the altered skin integrity had been brought forth to staff by the SDM. The DOC indicated that staff should have assessed the area of altered skin integrity when they were first made aware of it, by the SDM. (638) [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint was submitted to the Director where the complainant indicated that resident #002 had developed a condition which required an intervention. Please refer to WN #1 for further details.

Inspector #638 reviewed resident #002's health care records and identified in the eMAR a directive to "complete weekly wound note/assessment for each altered skin integrity area". The Inspector identified in the eMAR three dates whereby, it was indicated that a weekly wound assessment had been completed, by a check mark or a "9". The inspector reviewed resident #002's health care records and could not identify a weekly wound assessment for the first date that was marked as completed. For the second date marked as completed, the Inspector could only identify a progress notes which indicated that there was some confusion regarding the resident's altered skin integrity treatment. For the third date, a "9" was documented which indicated that a progress note had been completed; the Inspector was unable to identify the progress note.

The Inspector could only identify a completed assessment for the resident's altered skin

integrity on one date, which was two days after it had been documented that a weekly wound assessment had been completed.

During an interview with Inspector #638, staff member #112 indicated that the residents who had areas of altered skin integrity were assessed at least weekly. The assessment would be completed and the record kept in the resident assessments tab, in PCC. Staff member #112 indicated that this monitoring would be ongoing until the issue was resolved.

The home's policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program" last revised October 17, 2018, indicated that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #638 interviewed the DOC, who indicated that areas of altered skin integrity were monitored weekly and that the home implemented a process where they utilized an electronic device which photographed and measured the resident's wound. The DOC indicated that these assessments were documented in PCC. The Inspector reviewed the aforementioned dates with the DOC, with regards to weekly wound assessment. The DOC acknowledged that for the first date, no assessment had been completed, although it was documented as completed. For a later date, the DOC stated that although a wound assessment had been opened, the information had not been entered in the wound assessments.
[s. 50. (2) (b) (iv)]

3. A complaint was submitted to the Director regarding wound care for resident #004.

Inspector #627 reviewed the resident's health care records and noted that upon admission, the resident had an assessment completed for multiple areas of altered skin integrity.

The Inspector was unable to find any follow up assessments for the multiple areas of altered skin integrity.

Inspector #627 reviewed the home's policy titled "Resident Rights, Care and Services-Required Program", last revised October 17, 2018, which indicated that "a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or

wounds will have a weekly Skin and Wound Module through Point Click Care by use of IPOD, you must save and lock the "Skin and Wound Module" assessment and all documentation was generated into a weekly wound progress note.

Inspector #627 conducted separate interviews with four staff members who stated that when a resident had a skin integrity issue, the wound care orders were added to the medication and treatment administration record (eMAR/eTAR) and a wound assessment was to be done weekly. The registered staff members acknowledged that resident #004's wounds had not been reassessed the following week.

During an interview with Inspector #627, the Co-DOC acknowledged that weekly wound assessments were to be completed with every resident who exhibited altered skin integrity. [s. 50. (2) (b) (iv)]

4. Inspector #638 reviewed resident #010's health care records and identified in the eMAR, a directive to complete a "Weekly Ipod (wound) assessment" of areas of altered skin integrity, on a specified day of the week. Upon reviewing the eMAR, the Inspector identified that the staff had documented their assessments as completed on three specific dates.

The Inspector reviewed the progress notes and assessments in the electronic records for the aforementioned dates and could only identify, for the completed assessment for a specific date, a late entry progress note which indicated "Assessment: [of wound] and no new signs of infections or inflammation were observed". The Inspector was unable to identify any further assessments for each of the areas of altered skin integrity, using a clinically appropriate skin and wound assessment tool. The Inspector also noted that the staff member had created this notation nine days after the care had been provided.

During an interview with Inspector #638, staff member #134 indicated that they could not recall this specific notation, however, management may have directed them to go back and complete the note. The Inspector inquired what tools they would use to complete an assessment on an area of altered skin integrity. The staff member indicated that they had an electronic device that could be used to photograph the area and complete an assessment, but if there were no significant changes they may just leave a short message on the status.

The DOC and Inspector #638 reviewed resident #010's electronic health care records and progress notes. Upon reviewing the progress note assessment, the DOC indicated

that it was not a comprehensive assessment of resident #010's altered skin integrity and that staff should have used the electronic device to complete the assessment or use the progress note template for altered skin integrity assessments instead of a general progress note.

During an interview with Inspector #638, the previous Administrator indicated that they had reviewed this incident and identified that staff member #134 had been exhausted and missed using the proper assessment note. The Administrator indicated that ideally staff would be using either the electronic device to complete assessments or using the wound note in the progress notes which was also a clinically appropriate assessment tool. [s. 50. (2) (b) (iv)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A complaint was submitted to the Director regarding altered skin integrity for resident #004. Please see WN #2, item #3, WN #4, item #3, and WN #6, item 1, for details.

Inspector #627 reviewed resident #004's heath care records and noted resident #004 had a skin assessment completed upon their admission, for areas of altered skin integrity. The Inspector was unable to locate any further assessments of resident #004's areas of altered skin integrity. The Inspector also identified, in the "vitals tab" in PCC, that the resident had some abnormal vital signs since their admission.

Inspector #627 reviewed the home's policy titled, "Infection Control- Infection prevention and Control Surveillance Policy", last revised January 23, 2019, which indicated that the Registered Staff were to monitor for any change in condition, including signs and symptoms of infection, document in progress notes, using the infection note label, regarding the presence or absence of symptoms. On every shift, for those residents with infection or suspected infection, document in the progress notes, regarding the presence or absence of symptoms.

Inspector #627 interviewed staff member #129 who stated that when a resident exhibited certain symptoms of infection, they were to be monitored every shift. Staff member #129 stated that "this was what should have happened and obviously had not happened, staff should have been monitoring the resident".

Inspector #627 interviewed staff member #128 who stated that upon admission, a resident's vitals should be monitored for 72 hours. If the resident was identified as having abnormal vital signs, staff should have continued to monitor resident #004 every shift, the physician should have been informed as there was "something going on".

Inspector #627 interviewed the DOC who stated that when a resident had signs of infection, the physician should be called, the resident should be monitored, and the findings documented in progress notes, on every shift, and communicated to the oncoming staff and management, so the resident can get the proper care. The DOC acknowledged this was not done for resident #004. [s. 229. (5) (a)]

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. 19. Duty to protect

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone, and from neglect by the licensee or staff.

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

1) A complaint was submitted to the Director regarding care concerns regarding altered skin integrity for resident #004. The complaint identified that resident #004 was admitted to the home and had a significant change in health status, because the home failed to provide medication or physician involvement.

Inspector #627 interviewed the complainant who stated that they had met with the home upon admission of resident #004 and discussed resident #004's medical condition. The complainant was informed by the home that the resident's medical condition was extremely serious. The complainant stated that they had asked if resident #004 needed a specific intervention or to go to the hospital for care of the medical condition and were told that "the home had experts who could provide better care than the resident would receive in the hospital and, if the resident went to the hospital, they would probably come back in worst condition". The complainant stated that they figured "they (the home) knew what they were doing". The complainant became very emotional and further stated "I just don't know how Leacock didn't recognize it was that bad and try to do something about it." The complainant further stated that upon admission to the Emergency Department at the hospital, the physician had been very clear of the gravity of resident #004's medical condition.

Inspector #627 reviewed resident #004's medical health care records and noted resident #004 had a specific type of assessment completed, upon their admission. The Inspector was unable to locate any further assessments of resident #004's medical condition. The Inspector also identified, in the "vitals tab" in PCC that the resident had an abnormal vital sing which was documented on for three days.

The Inspector could not identify any other documented vital signs for resident #004 five days later, whereby the resident's abnormal vital sign was now within the normal range.

A further review of resident #004's progress notes, by Inspector #627, during the review, established a timeline of the resident's progressive deterioration.

During separate interviews with PA #117, NP #121, Physicians #131 and #132, they stated to Inspector #627 that they had not been made aware of resident #004 having an abnormal vital sign on the day of their admission and resident #004 deteriorating health status.

Inspector #627 interviewed the DOC who stated that if resident developed a specific abnormal vital sign, the nurse should complete and document an assessment. The DOC stated that if the abnormal vital sign remained after a specific intervention had been administered, the physician should be called, the oncoming shift should be made aware, as well as management on the floor. They stated that if the staff were unsure of what to do, they could reach out to management for advice. The DOC stated that staff should have kept monitoring the resident's vitals past the mandatory three days after their admission since the resident had an abnormal vital sign, and this had not been done.

Further non compliance was also identified under:
- Section (s.) 20 (1), of the Long-Term Care Homes Act, 2007; failure to comply with the home's policy prevention of abuse and neglect policy titled "Resident Rights, Care and Services – Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019;
- S. 50 (2) (b) (iv), of the Ontario Regulation (O.Reg.) 79/10; failure to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and,
- S. 229 (5) (a) of the O. Reg 79/10; failure to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

2) A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse. The complaint indicated that they had been made aware of an incident whereby resident #011 had been abused on a specific date, and that the home was not following their own abuse policy.

Inspector #627 interviewed the complainant, who was resident #011's enacted SDM. The complainant stated that they had received a telephone call from an RN, on a specific date, who had informed them of the alleged incident of abuse, and that they (the RN) would be reporting the incident to the Co-DOC. The complainant stated that they had called early morning, and at the end of the day when their call had not been returned, at which time they reached the Co-DOC. The complainant stated that they had been told by the Co-DOC that they had not interviewed resident #011 or called the police as the resident had "seemed fine". When the complainant inquired as to why the home's abuse policy was not being followed, the Co-DOC had told them (complainant) that the information given in the admission package was not the process that was followed in the home as they had a new internal process that the home followed. The complainant stated that they had asked for a report of the investigation when it was completed and had been told that they (Co-DOC) were not required to do this, however, they (Co-DOC) would call them in four days. The complainant told Inspector #627 that they felt the home was minimizing the incident, the home refused to call the police and that the complainant feared for resident #011's safety.

Inspector #627 interviewed resident #011 a specified number of days, after the incident. During the interview, resident #011's eyes became wide open when Inspector #627 asked if there had been an incident, and they indicated "yes", when asked if they recalled the incident. Resident #011 demonstrated to the Inspector what had occurred to them, and indicated that they were fearful this would occur again. The resident indicated "no", when the Inspector inquired if anyone had discussed the incident with them.

Inspectors #638 and #627 interviewed staff member #128 who stated that they were present in the home when the incident between resident #011 and resident #012 occurred. Staff member #128 reported that resident #012 had demonstrated a specific type of responsive behaviour towards resident #011. Staff member #128 stated that they had directed staff to interview the residents and to call them to inform and to monitor the residents to see if they were upset, as they may have to report the incident to MOH and the OPP. Staff member #128 further stated that they had not received a call back, nor did they follow up with staff members until two days later. Staff member #128 acknowledged

that they had not attempted to interview resident #011 and #012. Staff member #128 stated that they were unsure why there had been no documentation of the assessments in the resident's charts. Staff member #128 stated that they had received a call from resident #011's SDM who wanted to know if they had completed an investigation and called the police. Staff member #128 informed resident #011's SDM that they would call the police, however, they were directed by the previous Administrator not call the police, who wanted further investigations into the incident as they felt the incident should not be reported. Staff member #128 further stated that they had interviewed resident #011 five days after the incident and that resident #011 had communicated to them that they had negative feelings of the incident.

Inspector #638 and #627 interviewed the DOC who stated that the residents should have been interviewed, a report should have been made the MOH and the police should have been called. The DOC further stated that they had to follow the [previous] Administrator's directives.

Inspector #638 and #627 interviewed the previous Administrator who stated that they had felt the incident was not abuse but had then reported the incident to the Ministry and had called the police, five days after the incident had occured after the resident had been interviewed.

Further non compliance was also identified under:
- S. 20 (1), of the LTCHA, 2007; failure to comply with the home's policy prevention of abuse and neglect policy titled "Resident Rights, Care and Services – Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019;
- S. 24 (1), of the Long-Term Care Homes Act, 2007; failure to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.
- S. 231 (b) of the O. Reg 79/10; failure to ensure that the resident's written record was kept up to date, at all times;
- S. 98 of the O. Reg 79/10; failure to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence; and,
- S. 6. (10) (b), of the LTCHA, 2007, cited in Follow up inspection report, # 2019_752627_0015; failure to ensure that resident #012 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, or care set out in the plan was no longer necessary. [s. 19.]

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity.

A complaint was submitted to the Director regarding the home taking away resident #003's assistive device. Inspector #627 interviewed the complainant who stated that after resident #003 was admitted to the home, the resident demonstrated responsive behaviours with their assistive device. The complainant stated that although they understood the concern, many other residents had responsive behaviours but kept their assistive devices. The complainant stated that it was not right to remove resident #003's assistive device as it was the resident's way of negotiating the world. The complainant stated that other solutions were offered at a meeting, by the Behavioural Supports Ontario (BSO) staff, registered nurses, the physician and the PA, however the Administrator disregarded them. The complainant stated that they had discussed with the DOC, that the resident's assistive device not be taken away to which the DOC had agreed. The complainant stated that it was after the meeting that the resident's assistive device was taken away.

Inspector #627 reviewed resident #003's progress notes and identified the following:

- On a specific date, the Restorative Care Coordinator documented that " [Resident #003] was able to perform a specific activity well using their assistive device, and listed other interventions that were put in place to ensure the resident's well being".
- Five days later, (one day after the responsive behaviour incident), the resident's assistive device was removed and they were provided with another assistive device, which they were unfamiliar with.
- A later time, on the same day, the DOC documented that the [previous] Administrator had asked resident #003 if they used their assisstive device to which the resident had replied "yes". The Administrator had informed resident #003 that they wanted them "to try something different and would like for [them] to try using a different assisstive device as they had told the resident they felt that the other assistive device would be better for them.
- On a later day, a specific Specialist documented that they had provided resident #003 with a similar assistive device that the resident had previously,[an intervention was] in place to monitor safe use and safety plan was to be developed by BSO in the event of another incident. Once resident #003's assistive device was returned, resident #003 stated [they felt] better. Will continue to follow up and monitor use. Will continue to train and re-orientate resident, will be following up as well on a weekly basis and will be providing an in-home assessment to assist".

Inspector #627 interviewed resident #003 who stated that they required their assistive device. Resident #003 further stated "my [assitive device] was out of commission when I came in and I had no control over [a specific activity of daily living], for a couple of days at least. I am not sure how long". Resident #003 further stated that they had used the assistive device for years.

Inspector #627 interviewed staff member #103 who stated on the day of the incident, resident #003 was attempting to leave from the home and had demonstrated physical responsive behaviours. Staff member #103 stated that the following day, resident #003's assistive device was taken away from them, and that they were provided with a different assistive device. They stated that resident #003 was provided with an assistive device which they could not use. Staff member #103 stated they felt this was abuse.

Inspector #627 interviewed staff member #105 who stated that resident #003's assistive device was removed after they had an episode of responsive behaviours. Staff member #105 stated that they felt this was not helpful as resident #003 relied on their assistive device for their activities of daily living [ADLs]. They stated that resident #003 had lost all sense of independence.

Inspector #627 interviewed the specific Specialist who stated they received a referral for resident #003 after a responsive behavior incident had occurred. The home has asked them (Specialist) to come and assess the resident's need for the assistive device. The Specialist stated that resident #003 needed their assistive device and that the other device provided by the home was not useful to the resident, as they had used their assistive device for years. The specific Specialist stated that there had been a lot of "push back" from the home, specifically the [previous] Administrator, who wanted to know why the resident could not use another assistive device, instead of their usual one, to which they had told the home that resident #003 had not required the second assistive device but that they required theirs.

Inspector #627 interviewed staff member #115 who stated that there was an incident where resident #003 had demonstrated responsive behaviours. Staff member #115 stated that there was a meeting at a later date, where the risks of removing resident #003 's assistive device were discussed. Staff member #115 also stated that it had been discussed, that the previous Administrator had assessed resident #003 as needing a different assistive device, and that someone needed to put a "note in the chart" to support this, and that the DOC would follow up with the a specific staff member. Staff member #115 stated that they had told the previous Administrator that they were taking a big risk by removing resident #003's assistive device.

Inspector #627 interviewed two staff members who indicated that resident #003's assessment for the second assistive device was completed without a trial with their usual assistive device as it had been taken away the previous day. A specific staff member indicated that they had been told that the [previous] Administrator wanted the resident to be assessed as needing the second assistive, as the [previous] Administrator had not wanted the resident to have their usual assistive device.

Inspector #627 interviewed the DOC, who stated that resident #003's assistive device was taken away from them, for safety reasons, when an incident of responsive behaviour had occurred. The DOC further stated that nothing else had been trialed prior to removing resident #003's assistive device. The DOC stated that the [previous] Administrator wanted the resident's assistive device removed.

Inspector #627 interviewed the previous Administrator who stated that they had removed resident #003's assistive device when the resident had demonstrated responsive behaviours, due to safety concerns. The previous Administrator stated that they felt it

was important to respect resident's rights; however, it was their responsibility to ensure resident and staff safety. The previous Administrator acknowledged that nothing else had been trialed prior to removing the resident's assistive device, there had been no further incident, and that they had not trialed returning the resident's assistive device until the specific Specialist had assessed the resident. [s. 3. (1) 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 recognize the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #8: 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 has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, was immediately investigated.

Inspector #679 reviewed a concern/complaint form, on a specific date, written by staff member #114, who reported witnessing [resident #013] demonstrating responsive

behaviours towards resident #018. Please see WN #2, item #2, for details.

In the "Action Taken" section of the concern/complaint form, the Inspector identified the following; Writer notified DOC. Direction given. Writer spoke with resident [the following day], resident's POA notified [the following day] [Physician] notified [the following day]. Message left with co-resident's POA on the [following day]. Co-resident's POA called [three days later] and notified at that time".

In an interview with Inspector #679, staff member #114, identified that they were notified of the incident involving resident #013 and resident #018 by a staff member on the unit. Staff member #114 identified that they had contacted the DOC regarding the incident and that they were given direction from the DOC on what needed to be done, and that they were told that this could be done the next day. Staff member #114 further identified that the day after the incident, they spoke with resident #018, notified the SDM and updated the resident's care plan.

Inspector #679 reviewed email correspondence between the DOC and staff member #114. The email from the DOC identified what needed to occur and what needed to be documented. The email response by staff member #114 identified "I'll need help with this" to which the DOC responded, "Tomorrow is fine".

Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services-Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified that "the most Senior Administrative Personnel (or Charge Nurse if no manager in the home) who receives a report of resident abuse or neglect will: Assess the resident to determine any injury and provide any necessary care and ensure immediate support or assistance is provided to the resident who has been abused or neglected and assess the resident's condition, evaluating the safety, emotional and physical well-being. The policy further identified that staff were to commence a preliminary investigation by obtaining written and signed statements from all witnesses and documenting all pertinent information in the resident's record and complete resident incident reports.

Inspector #679 interviewed the DOC who identified that management was responsible for conducting investigations, and that the investigations were to be conducted right away. The DOC identified that when the home received an allegation of abuse, staff were to interview the staff member who witnessed the incident and conduct an interview with the residents. The DOC indicated that the interview with the residents should be right away,

regardless of the time of the day, and that they "can't leave it until the next day that management is in, that is too long".

The previous Administrator was not available for an interview. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During this inspection, staff member #110 approached Inspector #627 regarding staffing levels in the home, and the effect on resident care.

A) Inspector #679 interviewed staff member #113, on a specific date who identified that the home had worked short staffed on a specific time frame, and that there was some miscommunication about the reorganization of staff for the unit. Staff member #113 identified that as result of the miscommunication, resident #017 had not received their bath.

Inspector #679 reviewed the electronic progress notes and identified a progress note, which indicated "due to an incident [bed bath] not given".

Inspector #679 reviewed resident #017's electronic care plan which identified resident #017's bathing preference, which they had not received during the specific time frame.

Inspector #679 reviewed the "Bath List on a specific Home Area " and identified that resident #017 was to receive the preference which was a bath on a certain day, and a shower on another day.

Inspector #679 reviewed the electronic POC documentation for resident #017 and was unable to identify that the resident had received a bath or shower for a specific day. For the following day, "no" was documented for the task of: "Bathing- Tub Bath, Bed Bath, Shower".

B) Inspector #679 reviewed the Bath/Auditing Tool for another Home Area, for a specific date. The Inspector identified that residents #003, #020, #021, #022, #023 and #024, were all documented as having received a bed bath.

Inspector #679 reviewed the electronic progress notes for the above-mentioned residents and identified that the residents had received a bed bath on the specified dates, due to staffing levels.

Inspector #679 reviewed the resident's electronic care plans and identified that none of the residents had received their preference for the task of "Bathing- Tub Bath, Bed Bath, Shower".

C) Inspector #679 reviewed the bath list for another home area, and identified that residents #003, #020, #021, #022, #023 and #024 were to receive their scheduled bath/shower on specific dates

Inspector #679 reviewed the electronic POC documentation for the above listed residents and identified that non of the above mentioned resident had received a bath for a one week period.

In separate interviews with staff members #106, #113, #119, #141 and #143, they identified that when the home worked short staffed residents did not always receive their scheduled bath/shower.

In an interview with staff member #110, they identified that the residents were not offered their preferred bath/shower on the date in which they were documented as receiving bed baths.

In an interview with staff member #115, they identified the circumstances when a bed bath would be provided to a resident. Staff member #115 identified that it was the expectation that baths/showers were the priority, short staffed or not. Staff member #115 identified that if the resident's bath/shower was missed it should be offered the next available time, and it should not wait until their next bath date.

In an interview with the DOC, they identified that residents were offered two baths/showers per week. The DOC identified that a bed bath was the resident's preference, then it would be included within the residents two bath/showers per week; however, if it was not their preference then it would not be included in their two baths per week. [s. 33. (1)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date, at all times.

1) A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse. The complaint indicated that they had been made aware of an incident whereby resident #011 had been abused. Please see WN #2, item #4 WN #3, item #1, and WN #6, item 2, for further details.

Inspector #627 reviewed the home's investigation and identified two interviews with staff member #140, which indicated what staff member #140 had observed regarding the abuse of resident #011 by resident #012.

During an interview with Inspector #627, the previous Administrator indicated that they would like some time to review the incident and ensure they had all the details and they would reconvene at the beginning of the next week, when the Inspectors returned.

On a specific date, when the Inspectors returned to the home, Inspector #638 identified that staff members had written multiple late entry notations (13 new notations) related to the incident between resident #011 and #012.

Inspector #627 interviewed staff member #119 who stated that they had been asked to enter a late entry by staff member #129, providing more details. They further stated that they documented care when it occurred, however, usually management completed investigations and they were unsure how to proceed.

In an interview with Inspector #638 and Inspector #627, staff member #128 indicated they couldn't speak on behalf of the other staff members' recall related to the late entries but that they had a very good memory. Staff member #128 indicated that they documented everything related to the investigation in the concern/complaint form, but had not documented the verbal interactions with staff related to this incident. The Inspector inquired if they documented verbal interviews that were a part of an abuse investigation, to which staff member #128 indicated that they "didn't get around to it" but it was supposed to be documented and it had been their plan to document "yesterday" (five days after the incident), "but you (Inspectors) had already picked up on the incident".

During an interview with Inspector #638 and Inspector #627, the previous Administrator indicated that documentation related to resident status and care was expected to be

documented within the shift. The Inspector inquired why staff were not documenting all their actions at the time of the incident to which the previous Administrator indicated they had been dealing with and investigating to identify "who's done what". The previous Administrator indicated they had directed staff to go back and complete documentation when they asked staff questions in light of Inspector #627's resident interview and then had asked the staff to go back and include the notes. The previous Administrator confirmed that staff should have documented their notes during the shift it occurred.

2) Inspector #638 reviewed resident #010's health care records and identified that the resident had altered skin integrity. Please see WN #4, item #4, for further details.

The Inspector reviewed the progress notes and assessments in the electronic records for three specific dates, and could only identify late entry progress note, documented by staff member #134, which indicated a list of areas where resident #010 had impaired skin integrity with a notation that there was "no new signs of infections or inflammation were observed". The Inspector also noted that the staff member had created this notation nine days after the care had been documented as provided.

During an interview with Inspector #638, staff member #134 stated that they did not recall documenting their assessment nine days after care was provided, but management would have notified them to enter a progress note when it was identified that they had not completed the assessment.

During an interview with Inspector #638, the previous Administrator indicated that they had reviewed this incident and identified that staff member #134 had been exhausted and missed using the proper assessment note and skin assessment, which was documented several days after care had been provided. [s. 231. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's written record is kept up to date, at all times, to be implemented voluntarily.

WN #11: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff in the home had received training as required for all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that were relevant to the person's responsibilities.

Inspector #627 was made aware of an alleged incident of abuse from resident #013 towards resident #017. Please see WN #3, item #3, for details.

Inspector #627 reviewed resident #013's care plan in effect at the time of the inspection and noted for the focus of a [specific type of responsive behaviour], interventions which included a specific assessment, which was to be completed when the resident exhibited the specific type of responsive behaviour. The interventions were directions for the PSWs.

Inspector #627 interviewed staff member #145 who stated that they had not been provided training in regard to completing the specific assessment, which was part of resident #013's directions on how to provide care to the resident.

Inspector #627 interviewed staff member #146 who stated that they had not received any training from the home, regarding completing the specific assessment. Staff member #146 stated they would not know how to complete the specific assessment and would report the occurrence to the registered staff.

Inspector #627 interviewed staff member #113 who stated that the interventions in resident #013's care plan told them nothing. Staff member #113 stated that resident #113 was not acting "as their norm", and therefore, staff member #113 stated that they could not complete the assessment.

Inspector #627 interviewed staff member #114, who stated that staff had not received training in regard to completing a specific assessment when resident #013 demonstrated specific responsive behaviours and that the teaching was more "on the spot".

Inspector #627 interviewed the DOC who stated that front line staff had not received any training in regard to completing an assessment when resident #013 demonstrated specific responsive behaviours.[s. 76. (2) 10.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker, if any, and any other person specified by the resident were notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector #627 was informed of an alleged resident to resident abuse between resident #013 to resident #017, during an interview with staff member #115. Please see WN #3, item #3, for details.

Inspector #627 reviewed the home's investigation notes and identified a written statement by staff member #136. The statement indicated what staff member #136 had observed the incident between resident #017 and #013.

Inspector #627 reviewed the home's policy titled, "Resident Rights, Care and Services – Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019, which indicated that the most senior administrative personnel who received a report of resident abuse or neglect will immediately notify the resident's substitute decision maker (SDM) or any person specified by the resident of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. In all other cases, notification must be provided within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector #627 reviewed resident #013's progress notes and could not identify a progress note which indicated that resident #013's SDM had been made aware of the incident.

Inspector #627 interviewed staff member #114 who stated that the incident had been reported to them by staff member #136, that the DOC had also been advised and would be "taking over" the investigation. Staff member #114 stated that they had not been involved in the follow up.

Inspector #627 interviewed the DOC who stated that they had called resident #013's SDM, two days after the incident, when they realized that staff member #114 had not called. They acknowledged that the SDM should have been called immediately when staff became aware of the incident. [s. 97. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

A complaint was brought forth to the Director, in regard to an alleged incident of resident to resident abuse between resident #011 and #012. Please see WN #2, item #4 WN #3, item #1, and WN #6, item 2, for further details.

During an interview with Inspector #627, the complainant, who was the enacted SDM for resident #011, stated that they had spoken to staff member #128, and asked for the police to be called as the home's policy stated, to which staff member #128 stated that the home had an internal process and did not follow the home's abuse policy. The complainant stated that when they had asked staff member #128 to call the police, they had replied "who would you like me to call exactly", which the complainant stated made them feel like the home was minimizing the incident.

Inspector #627 reviewed the home's policy titled, "Resident Rights, Care and Services – Abuse_ Zero-Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019, which instructed to "notify immediately the appropriate police force of any alleged, suspected or witnessed incident of abuse that may constitute a criminal offence".

Inspector #627 interviewed staff member #140, who described their observation of the resident to resident abuse incident. They further stated that they had reported the incident to a PSW.

Inspector #627 interviewed staff member #119, who stated that they had inquired to staff member #128 about calling the police. Staff member #119 stated that they had been

informed that the home had a new process for "dealing with those types of incidents" and that it was management, "higher up", who had changed the process for calling the police and reporting incidents of alleged abuse.

Inspector #627 interviewed staff member #129, who stated that the home's policy was to call the police when there were allegations of suspected abuse. They further stated that they were unsure why the police had not been called for the alleged abuse between resident #011 and #012.

Inspector #627 interviewed staff member #128 who stated that they had brought forth the incident to the previous Administrator who had decided that the police should not be called.

In a subsequent interview staff member #128 indicated that they had formally interviewed resident #011 for the first time, five days after the incident, and had called the police at this time, five days after the incident.

The previous Administrator was not available for an interview. [s. 98.]

Issued on this 1st day of October, 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) :	SYLVIE BYRNES (627), MICHELLE BERARDI (679), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2019_752627_0016
Log No. / No de registre :	009136-19, 011306-19, 011720-19, 014455-19, 014725-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 25, 2019
Licensee / Titulaire de permis :	Orillia Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Leacock Care Centre 25 Museum Drive, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Vittoria Trainer

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Orillia Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 section 6 (7), of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that the care set out in the plan of care is provided to all residents as specified in their plan.

Grounds / Motifs :

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

A complaint was submitted to the Director which indicated that resident #002 had developed a physical condition, which led to medical interventions. The complaint alleged that the physical condition kept worsening with no improvement, which negatively effected the resident's status and outcomes.

Inspector #638 reviewed resident #002's health care records and identified that the resident had an intervention in place, on a specific date. The physician's orders identified that the intervention was to be discontinued at a later specific date.

Inspector #638 reviewed the electronic medication administration record (eMAR), and identified a scheduled due date for discontinuation of the intervention. The Inspector reviewed the progress notes and identified that the intervention was not discontinued on the specified date, and that the Nurse Practitioner (NP) was unsure of what action to take and directed the staff member #118 to continue the intervention for a few more days. The Inspector was unable to identify any written orders related to the direction the NP provided

in the progress notes.

Inspector #638 interviewed staff member #111. They indicated that they based care on the physicians' orders and that they were required to follow the orders, within reason, for resident care. The Inspector reviewed the eMAR task scheduled for a specific date, related to discontinuing the intervention, with the staff member. Staff member #111 stated that the task was clear and that it directed them to discontinue the intervention on a specific date but indicated that staff had not received education related to the specific intervention.

During an interview with Inspector #638, staff member #112 indicated that registered staff were expected to assess, manage and treat resident #002's physical condition. The Inspector reviewed the eMAR task regarding the specific intervention, with the staff member. The staff member indicated that it was clearly outlined that the intervention was to be discontinued on a specific date.

Inspector #638 interviewed staff member #114 who indicated that they had discontinued the specific intervention on a specific date; two days later than was indicated on the physician's order. The staff member indicated that there had been some confusion surrounding the specific intervention and that they sought direction from the NP. The NP directed the staff to continue the specific intervention for another day or two. Staff member #114 indicated that they had not believed the NP wrote an order for this direction and just verbalized this to the staff member. The Inspector reviewed the eMAR task with staff member #114 who indicated that they had not been aware that the order had been identified in the eMAR and that it was clear, based on the eMAR, that they were to discontinue the specific intervention on a specific date.

In an interview with Inspector #638, NP #121 indicated that staff member #118 contacted them on a specific date, related to resident #002's specific intervention. The NP indicated that they had instructed the staff member to continue the specific intervention, but were unsure if an order had been written. The NP indicated that they had not consulted the physician related to the intervention and were unsure when the specific intervention had first been administered; therefore, they directed staff to continue the specific intervention.

The Inspector reviewed the physician's orders again and was unable to identify any orders to continue with the specific intervention.

In an interview with Inspector #638, staff member #118 indicated that they were looking after resident #002 on a specified date. The staff member indicated that they were unsure when the specific intervention was to be discontinued, although the eMAR had directed them to discontinue the intervention on a specific day. The staff member indicated that they were unable to contact the physician to clarify the orders and that staff member #114 had directed them to inquire with the NP. The staff member indicated that the NP had provided verbal direction to continue the specific intervention, but they had not written an order and had written the direction in a progress note instead.

Inspector #638 reviewed the home's policy titled, "Resident Rights, Care and Services – Plan of Care", last revised March 13, 2018, which indicated that registered staff were to ensure that care was provided to the residents as specified in the plan of care.

In an interview with Inspector #638, the Director of Care (DOC) indicated that treatment and direction related to the specific intervention was kept in the eMAR. Upon reviewing the direction for the specific intervention with the DOC, they indicated that the direction appeared clear, however, the staff member may have gone back and reviewed the physician's orders and became confused regarding the date to discontinue the specific intervention. The DOC and the Inspector reviewed the progress notes and identified the direction from the NP. The DOC indicated that they were unsure if the NP had the capacity to give this sort of direction and they were unsure if they had written an order or if it was only verbalized. Upon reviewing all the information, the DOC indicated that the staff member may have been afraid to discontinue the specific intervention and indicated that the specific intervention should have been discontinued, but due to the confusion surrounding the order, they followed the NP's direction. [s. 6. (7)]

The severity of the issue was determined to be a level 3 as there was actual risk of harm to the resident. The scope of the issue was a level one as it was isolated. The home had a level 3 history, which indicated one or more non-compliances which were the same section or subsection being cited:

- Voluntary Plan of Correction (VPC) issued in March, 2019, in report 2019_671684_0013,
- VPC issued in October 2018, in report 2018_657681_0025,
- VPC issued October 2017, in report 2017_486653_0019, and
- VPC issued April 2017, in report 2017_646681_0011. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 25, 2019

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 : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with section 20 (1), of the Long-Term Care Homes Act, 2007.

Specifically, the licensee shall ensure that all staff are compliant with the home's policy to promote zero tolerance of abuse and neglect of all residents.

Grounds / Motifs :

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

Neglect is defined in the Ontario Regulation 79/10, as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A) On a specific date and time, Inspector #638 observed staff member #106 and [staff member] #123 approach staff member #113 and inform them that resident #005 was exhibiting specific medical symptoms. Staff member #106 and [staff member] #123 reported to staff member #113 that the resident received a specific intervention when they exhibited specific medical symptoms. Staff member #113 stated, without assessing the resident or checking their plan of care, that they were not comfortable providing the specific intervention and would report resident #005's specific medical symptoms to the next shift. The Inspector noted that staff member #106 and [staff member] #123 re-iterated that the resident required the specific intervention for the medical symptoms.

A review of resident #005's care plan identified a goal, to reduce frequency of the above mentioned medical symptoms. Inspector #638 reviewed the medical orders for resident #005 and identified in the orders section on Point Click Care (PCC) that the resident was ordered a specific intervention when they demonstrated specific medical symptoms.

Inspector #638 interviewed [staff member] #123, who indicated that they informed staff member #113 of resident #005's specific medical symptoms, because they were normally given a specific intervention to help minimize the symptoms.

During an interview with staff member #113, when asked by the Inspector the status of resident #005, they indicated that they did not know the resident, but staff had just reported that the resident was having specific medical symptoms. Staff member #113 went on to state that they were "not comfortable administering [the specific intervention] to people they didn't know"; and they were "not sure of these residents". The Inspector inquired what action was taken when resident #005 was experiencing the above mentioned specific medical symptoms to which staff member #113 indicated that "a lot of people go straight to [the specific medical intervention], but I don't". The Inspector followed up asking why the specific intervention was not provided to resident #005 as they were demonstrating the specific medical symptoms for which the specific intervention had been ordered for? Staff member #113 stated that they had "not assessed the resident [to determine their needs] and [they] did not know the resident at all and were not comfortable providing the [specific intervention] at this time". The staff member stated that they would report the specific medical symptoms to the next shift.

Inspector #638 interviewed staff member #114, at the beginning of the following shift They indicated that they had been made aware of staff member #113's hesitance to provide resident #005 with the specific medical intervention, which was requested by [staff member] #123. Staff member #114 indicated that they believed staff member #113 was hesitant to provide the intervention, without checking. Staff member #114 stated to the Inspector that they informed staff member #113 to provide the intervention because resident #005 was exhibiting specific medical symptoms. Staff member #114 indicated that staff were

expected to check the care plan if they were unsure of resident needs.

The Inspector sat near resident #005's room until approximately one hour and a half after staff member #113 had completed their shift. During the observation, the Inspector did not observe staff member #127 assess or inquire about the resident's well being, including if they were having specific medical symptoms. The Inspector had not observed staff member #113 assess nor write a progress note related to resident #005's condition prior to staff member #113 leaving. During an interview with the Inspector, staff member #127 indicated that staff member #113 reported that resident #005 had received another intervention; however, there was no mention of the resident's reported medical symptoms.

Inspector #638 followed up with the staff member #114. Staff member #114 indicated that they were expecting staff member #113 to provide resident #005 with the specific medical intervention and stated they heard staff member #127 state that both them and staff member #113 were going to check on the resident. The Inspector reviewed the documentation records with staff member #114, who indicated that staff member #113 should have documented on the resident's status, if they went down to see the resident. At that time, staff member #114 went and checked resident #005's status to ensure they were not in any distress.

The Inspector followed up on the following day and identified in resident #005's records that they had received the specific medical intervention, approximately three and a half hours after the medical symptoms were initially reported.

In an interview with Inspector #638, Physician Assistant (PA) #117 indicated that resident #005 was provided the specific medical intervention to manage specific medical symptoms. The PA indicated that they were not concerned with the interactions being provided along with a separate intervention since the resident "suffers quite a bit".

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being

of one or more residents.

In an interview with Inspector #638, the Co-Director of Care (Co-DOC) #128 indicated that the home defined neglect as a pattern of inaction toward resident care. Co-DOC #128 indicated that a staff member not knowing a resident was not an appropriate reason to not provide an intervention. Co-DOC #128 stated that staff can review the care plan, eMAR, progress notes or consult with someone to identify what is normal for the resident. The Inspector reviewed the combination of issues observed by the Inspector related to staff member #113; not reviewing resident #005's plan of care, not assessing the resident and not documenting what had been reported, not reporting the symptoms on shift report and not providing the intervention which managed resident #005's symptoms, with Co-Doc #128. After review, the Inspector inquired if staff member #113 demonstrated a pattern of inaction in this instance, to which the Co-Director of Care stated "yes". [s. 20. (1)] (638)

2. A) Inspector #679 reviewed a concern/complaint form written by staff member #114. The description of the concern identified [staff member #144] reported witnessing an incident between[resident #013] demonstrating a specific responsive behaviour towards [resident #018's].

Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified that "the most Senior Administrative Personnel (or Charge Nurse if no manager in the home) who receives a report of resident abuse or neglect will: Assess the resident to determine any injury and provide any necessary care and ensure immediate support or assistance is provided to the resident who has been abused or neglected and assess the resident's condition, evaluating the safety, emotional and physical well-being.

Inspector #679 reviewed resident #018's electronic progress notes regarding the incident and could not identify any notes indicating that the resident was assessed or interviewed about the incident.

Inspector #679 interviewed staff member #114 who identified that they were notified of the incident involving resident #013 and resident #018 by a staff member on the unit. Inspector #679 questioned if resident #018 had been

assessed after the incident, and staff member #114 identified "No… looking back I should have talked to [them]".

B) Inspector #679 reviewed the home's policy titled "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019. The policy identified that staff were to commence a preliminary investigation by obtaining written and signed statements from all witnesses and documenting all pertinent information in the resident's record and complete resident incident reports.

Inspector #679 reviewed the electronic record and was unable to identify that a resident incident report was completed for this incident.

Together, Inspector #679, #627, and the DOC reviewed the electronic risk management section of PCC. The DOC identified that an incident report had not been completed.

C) Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified "Immediately notify the resident's substitute decision maker or any person specified by the resident of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. In all other cases, notification must be provided within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident".

During the interview with staff member #114, they identified that they were notified of the incident involving resident #013 and resident #018 by a staff member on the unit, on a specific date and time. Staff member #114 indicated to the Inspector that the day after the incident, they spoke to the resident and notified the substitute decision maker (SDM).

Inspector #679 reviewed resident #018's electronic progress notes and identified a note documented 19 hours after the incident which indicated that the writer had "left a voice mail with [SDM] pending call back at this time".

Inspector #679 reviewed resident #013's electronic progress notes and identified a note, written by staff member #114 more than 18 hours after the incident, which identified that the SDM had been informed.

The previous Administrator was not available for an interview. [s. 20. (1)] (679)

3. 3. Ontario Regulation (O.Reg.) 79, of the Long-Term Care Home Act, 2007, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern or inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Director regarding the lack of treatment resident #004 had received in regard to a medical condition, which had led to a significant change in their health status. Please see WN #6, item #1, for further details.

Inspector #627 interviewed the complainant who stated that resident #004 was admitted to the home on a specific date and within a specific time frame, had a significant change in their health status.

Inspector #627 reviewed resident #004's medical health care records and noted resident #004 had a specific type of assessment completed upon their admission, for a medical condition they were admitted with. The Inspector was unable to locate any further assessments of resident #004's medical condition. The Inspector also identified, in the "vitals tab" in PCC that the resident had an abnormal vital sign since their admission, for a period of three days, at which time, the monitoring of the resident's abnormal vital sign was discontinued. The Inspector could not identify any other documented vital sign until a specific number of days.

A further review of resident #004's progress notes, by Inspector #627, during the review period established a timeline of the resident's progressive deterioration.

Inspector #627 reviewed the home's policy titled, "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last

revised April 25, 2019, which defined neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the heath, safety or well-being of one or more residents".

Inspector #627 interviewed staff member #110 who stated that when a resident was admitted, they received a complete head to toe assessment and their vital signs were monitored for three days to establish a baseline. If the resident presented with abnormal vital signs, then the resident's vital signs would be monitored for a longer period of time, until the vital signs were within the normal range. Staff member #110 further stated that if a resident had a specific medical condition, a specific assessment would be completed. Staff member #110 stated that if a resident with a specific medical condition developed a specific abnormal vital sign, they would notify the physician immediately, whereby they may be ordered a specific medical intervention. They stated that if they were unsure who the resident's physician was, they would notify the Co-Doc.

Inspector #627 interviewed staff member #113 who itemized specific signs and symptoms which would identify that the resident's condition was deteriorating, and that the physician should have been called when the resident exhibited the signs and symptoms. Inspector #627 and staff member #113 reviewed resident #004's health care records and noted that staff member #113 had documented that the resident had abnormal vital signs on their admission day. Staff member #113 stated they had made staff member #129 aware, although they had not documented the reporting. Staff member #113 also stated that they had discussed the resident with the Co-DOC, however, they had not reported the abnormal vital signs to a physician, the PA or the NP.

Inspector #627 interviewed staff member #129, who stated that they had assisted staff member #130 with resident #004's admission. Staff member #129 stated that they had not been made aware that the resident had developed abnormal vital signs. Staff member #129 stated that the first time they had been made aware of the abnormal vital signs, they had asked staff member #119 to reach out to Physician #131. They further stated that any abnormal vital signs would have been documented on the shift report to make the DOC and the following shift aware, to ensure that the resident was monitored for further abnormal signs. Staff member #129 stated that they had not made Physicians

#131 and #132, the PA or the NP aware of the resident's abnormal vital signs.

Inspector #627 interviewed staff member #119 who stated that their only involvement with resident #004 was on the day of their admission and that they had called Physician #131 for admission orders only. They further stated that they had only been helping and not assigned to the unit, and only assisted with obtaining admission orders for resident #004, and that they had not been in contact with any other physician, the PA, or the NP.

Inspector #627 interviewed staff member #127 who stated that when resident #004 had developed abnormal vital signs, they had reported it to the oncoming shift, but had not reported to a physician, or the Co-DOC. They stated that on a specific date, seven days after the resident's admission, they had posted a message on the communicator to advise Physician #132 and the PA, that the resident's condition had deteriorated. Staff member #127 stated that they had written that the resident's specific vital sign "remained within the norm", to indicate that the vital sign was normal at this time, although it had been abnormal upon admission and for the following two days after the admission when the resident's vital signs were monitored, as they thought that the abnormal findings were due to a different medical condition.

Inspector #627 interviewed the PA who stated that they were made aware that resident #004's care was transferred to Physician #132 on the day prior to the resident being transferred to the hospital. The PA stated that they were unfamiliar with the resident when they reviewed staff member #127's message on the communicator. The PA further stated that emergencies were not communicated on the communicator; the physician was called for anything urgent. The PA further stated that they had not been made aware of the resident's other abnormal vital signs, or they would have ordered specific interventions immediately.

Inspector #627 interviewed Physician #131 who stated that the home had contacted them three days after resident #004 was admitted to the home, for admission orders, at which time, they had informed the home that they were transferring the care of resident #004 to Physician #132. Physician #131 stated that they had not been made aware at any time that the resident's abnormal vital sings, or they would have instructed the staff member to make Physician #132

aware right away.

Inspector #627 interviewed Physician #132 who stated they had not had the opportunity to meet with resident #004. Physician #132 stated that the staff could have called them if they had concerns regarding the resident, as they were the Medical Director, and a physician was on call during off hours (evening, night and weekends). After reviewing resident #004's abnormal vital signs and symptoms, Physician #132 stated that the resident should have been sent to the hospital.

Inspector #627 interviewed staff member #128 who stated that every morning, management read the 24-hour shift report and discussed concerns at this time. Staff member #128 stated that if a resident developed abnormal vital signs, staff members should continue to assess the resident's vital signs and notify a physician as this would indicate that something was going on.

Inspector #627 interviewed the DOC who stated that if resident developed a specific abnormal vital sign, the nurse should have completed and documented an assessment. The DOC stated that if the abnormal vital sign remained after a specific intervention, the physician should be called, the oncoming shift should be made aware, as well as management on the floor. They stated that if the staff were unsure of what to do, they could reach out to management for advice. The DOC stated that staff should have kept monitoring the resident's vitals past the mandatory three days after their admission and this had not been done.

The previous Administrator was not available for an interview. [s. 20. (1)] (627)

4. 4. A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse. Please see WN #6, item #2, for further details.

Inspector #638 reviewed resident #011's progress notes and identified a late entry created six days after the incident which described how a staff member had reported they had witnessed a responsive behaviour resident #012 had exhibited toward resident #011. The notation indicated that the Co-DOC had given directions to be followed to assist them in determining if they needed to report to MOH and the police.

The Inspector noted that there was no indication in the investigation or progress notes, that anyone had interviewed the residents, related to the incident. The progress note created five days after the incident outlined that staff member #116 met with resident #011. Staff member #116 asked the resident how they felt at the time of the incident, resident #011 responded negatively, and communicated what had ensued during the incident.

Inspector #638 and Inspector #627 interviewed staff member #128 who indicated that they had directed staff member #119 and staff member #129 to interview resident #011. Staff member #128 also indicated they had directed staff members #119 and #129 to call back with a follow up on the incident. The Inspectors inquired if any staff members had called them back to report the outcome of this concern. Staff member #128 indicated that staff member #119 and #129 had not called them back and they had followed up with the staff members two days after the incident.

In a subsequent interview staff member #128 indicated that they had formally interviewed resident #011 for the first time five days after the incident, after Inspector #627 had met with the resident. Staff member #128 indicated that resident #011 had negative feelings regarding the incident. Staff member #128 stated that they spoke to Ontario Provincial Police to report the incident, five days after the incident had occurred. Staff member #128 also stated that no staff were interviewed on the date of the incident and they had difficulties getting a hold of the staff member who had witnessed the incident and obtained their account of the incident, four days after the incident.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019, indicated that the Administrator or Director of Care or the Manager On-Call will interview the resident, other residents and any other person who may have any knowledge of the situation.

During an interview with the previous Administrator, the Inspectors inquired if anyone had interviewed the resident at the time of the incident, or any time prior to the follow up interview they conducted, after Inspector #627 had brought these concerns forward, five days after the incident. The previous Administrator

was unsure and indicated they would need the weekend to determine if staff member #119 had interviewed resident #011 or if they just observed the resident's status on the day of the incident. There were no records provided to the Inspectors to support that any interview had occurred with the resident until five days after the incident.

The severity of the issue was determined to be a level 2 as there was minimal harm or minimal risk to the residents. The scope of the issue was a level 3; widespread, as it was related to 3 of 3 residents reviewed. The home had a level 3 history of noncompliance which indicated one or more non-compliances, one of which is the same subsection or section being cited:
- VPC March 2019, cited in inspection report 2019_671684_0013, and,
- VPC October 2018, cited in inspection report 2018_657681_0025. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 25, 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with section 24 (1), of the Long-Term Care Homes Act, 2007.

Specifically, but not limited to, the licensee shall:
1) Develop and implement a system whereby a staff member with reasonable grounds to suspect that abuse or neglect has occurred or may occur, will immediately report the suspicion and the information upon which it is based to the Director.
2) Design a tool to assist staff members, itemizing all the steps to follow, when a person becomes aware of alleged abuse or neglect. The tool shall identify in chronological order what steps are to be taken, indicating the time frame for each step to occur, and provide for a signature area indicating the step was completed.
3) Educate staff members, who may be involved in reporting to the Director, on the new system and the use of the tool.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Inspector #627 reviewed a memorandum, "Reporting Requirements Under the Long-Term Care Homes Act, OLTCA Conference", dated November14, 2018, sent by the Director to the Long-Term Care Homes Licensee and Administrators, and posted on the Long-Term Care Homes online Portal, reporting site, which indicated that: "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. 2) Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident".

A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse by resident #012 to resident #011. Please refer to WN #2, item #4 and WN #6, item #2, for further information.

Inspector #627 interviewed the complainant, who was resident #011's enacted SDM. The complainant stated that they had received a telephone call from an RN, who had informed them that a resident had demonstrated responsive behaviours towards resident #011, and that they (the RN) would be reporting the incident to the Co-DOC. The complainant stated that they had called early one morning, and at the end of the day when their call had not been returned, at which time they reached the Co-DOC. The complainant stated that they had been told by the Co-DOC that they had not interviewed resident #011 or called the police as the resident had "seemed fine". When the complainant inquired as to why the home's abuse policy was not being followed, the Co-DOC had told them (complainant) that the information given in the admission package was not the process that was followed in the home as they had a new internal process that the home followed. The complainant stated that they had asked for a report of the investigation when it was completed and had been told that they (Co-DOC) were not required to do this, however, they (Co-DOC) would call them in four days. The complainant told Inspector #627 that they had felt that the home was minimizing the incident, the home refused to call the police and that they feared for resident #011's safety.

Inspector #627 interviewed resident #011, five days after the incident. During the interview, resident #011 communicated to the Inspector what had occurred during the incident and that they remained fearful this could occur again.

Inspector #638 and Inspector #627 reviewed the Ministry of Long-Term Care's online Critical Incident System (CIS) reporting portal and were unable to identify that a CIS report had been submitted for this allegation of resident to resident abuse.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 25, 2019, indicated that suspected and or confirmed allegations of abuse shall be reported immediately as described in the following procedure; During business hours, notify the Ministry of Health and Long-Term Care immediately by way of the Critical Incident System (CIS) report.

Inspector #638 and Inspector #627 interviewed staff member #128 who indicated that immediate reporting was required when there was knowledge of suspicion of abuse. They indicated they had a hard time figuring out what happened as staff member #119 and #129 failed to call them back as requested.

During an interview with Inspector #638, the DOC indicated that abuse was immediately reported. They indicated staff would generally find out basic information surrounding the incident, which "shouldn't take much" and then report to the Ministry. Inspector #627 inquired if this incident should have been immediately reported, the DOC indicated that they should have reported the suspicion to the Ministry.

Inspector #638 and Inspector #627 interviewed the previous Administrator. They indicated that they followed the Ministry abuse decision tree and although the requirement was to immediately report, they do not report until they reached that part on the decision tree that directed them to report. Therefore, they only reported the incident once they were one hundred per cent sure the incident was abuse, which they had only determined five days after the incident, at which time they had reported the incident to the Director. [s. 24. (1)] (627)

2. Inspector #679 reviewed a concern/complaint form written by staff member #114. The description of the concern identified that [staff member #144] reported witnessing [resident #013] demonstrating responsive behaviours towards resident #018. Please see WN #2, item #2, for further details.

Inspector #679 reviewed the Ministry of Long-Term Care's online CIS reporting portal and was unable to identify that a CIS report was submitted for this allegation of resident to resident abuse.

Inspector #679 reviewed the home's policy titled, "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified: 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 Ministry of Health and Long Term Care: 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.

Inspector #679 reviewed a copy of the [Licensee Reporting of Abuse] decision tree which was attached to the concern/complaint form. The decision tree had a hand-written note at the top which identified that the incident was not abuse, due to resident #018's behaviour after the incident.

In an interview with Inspector #679, staff member #144 described the responsive behaviour that resident #013 had demonstrated toward resident #018. Staff member #144 identified that looking back on the incident, they would consider it abuse.

In an interview with Inspector #679 and #627, staff member #114 identified that they were made aware of the incident by the staff member who was working on the unit. Staff member #114 identified that staff member #144 observed resident #013 demonstrating responsive behaviours towards resident #018. Staff member #114 identified that the previous Administrator had directed them to write that resident #018 was not upset or crying. Staff member #114 identified that they had a suspicion that this was abuse and that they felt this should have been reported; however, as per the direction given from the management of the home, it was not reported.

Inspector #679 and #627 interviewed the DOC who identified that when an allegation of abuse was brought forward to the home, they would follow the decision tree and discuss the incident as a team prior to reporting it to the Director. The DOC confirmed that a report was not submitted to the Director

regarding this incident because it was discussed that it was not abuse.

The previous Administrator was not available for an interview. [s. 24. (1)] (679)

3. Inspector #627 reviewed investigation notes for alleged abuse by resident #013 to resident #017, which was observed by staff member #136. In a written statement, staff member #136 described that they had witnessed resident #013 demonstrating responsive behaviours to resident #017.

Inspector #627 reviewed the Ministry of Long-Term Care's online CIS reporting portal and was unable to identify that a CIS report was submitted for this allegation of resident to resident abuse.

Inspector #627 reviewed the home's policy titled, "Resident Rights, Care and Services- Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019. The policy identified: 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 Ministry of Health and Long Term Care: 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.

Inspector #679 reviewed a copy of the [Licensee Reporting of Abuse] decision tree, which was attached to the concern/complaint form. The decision tree had a hand-written note at the top which identified, that [the responsive behaviour had been interrupted, therefore, it was not abuse].

In an interview with Inspector #679 and #627, staff member #114 identified that they were made aware of the incident by the staff member #136, who was working on the unit, however, they had been advised that the DOC was taking over the investigation. Staff member #114 indicated that according to the home's abuse policy, this was abuse.

Inspector #627 interviewed the DOC who stated that they had been made aware of the incident when they had received a report from staff member #136 and believed staff member #114 had been made aware as well. The DOC acknowledged that according to the home's abuse policy, the incident was

abuse. The DOC stated that they had followed the decision tree, and along with the Administrator (Administrator at the time of the inspection), they had decided this was not reportable.

The previous Administrator was not available for an interview. [s. 24. (1)]

The severity of the issue was determined to be a level 1 as there was no harm or risk of harm to the residents. The scope of the issue was a level 3, widespread, as it was related to 3 of 3 residents reviewed. The home had a level 3 history of non-compliance which indicated one or more non-compliances, one of which is the same subsection or section being cited:
- Written notification (WN) in March 2019, cited in inspection report #2019_671684_0013.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2019

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with section 50 (2) of the Ontario Regulations (O.Reg.) 79/10.

Specifically, the licencee shall ensure that:

1)
All residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds;
a) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.
b) are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

2)
An Audit System is developed and implemented to ensure that required tasks are completed for every resident exhibiting altered skin integrity.

3)
The audits will be provided to the Inspector(s) upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was submitted to the Director where they indicated that resident #002 had altered skin integrity. The complaint alleged that the resident's altered skin integrity kept worsening with no improvement, which negatively effected the resident's status and outcomes.

Inspector #638 reviewed resident #002's health care records and identified in a progress note that the resident's SDM made staff aware of a new area of potential altered skin integrity. The progress note further indicated that if they could not come to assess and that the the following shift would assess. The Inspector was unable to identify any notes or assessments on the resident's new

area of altered skin integrity until four days later where it was identified that the area had worsened from the description provided by resident #002's SDM.

In an interview with Inspector #638, staff member #106 indicated that they monitored resident skin integrity during care giving periods and documented their findings in Point of Care (POC). Staff member #106 stated that if they identified a new area of altered skin integrity they would notify registered staff who would complete required assessments and treatment interventions.

During an interview with Inspector #638, staff member #111 indicated that whenever they were made aware of a new area of altered skin integrity, the area was to be assessed and treatment determined the day it was identified. The Inspector reviewed the date of identification and the date of the initial assessment with staff member #111, who indicated that they should have assessed and initiated interventions the day it was identified, instead of four days later.

Inspector #638 interviewed staff member #114 who indicated that resident #002 was identified as having a new area of altered skin integrity, after a review of the progress notes. Staff member #114 then identified that the initial assessment had occurred four days after the SDM had reported an area of altered skin integrity, and stated that staff should have done the assessment when it was first reported to them. The staff member indicated that this was important because once the assessment was completed staff would include interventions in the plan of care to manage the new area of altered skin integrity.

The home's policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program" last revised October 17, 2018, indicated that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds; received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, as required.

In an interview with Inspector #638, the DOC indicated that whenever a new area of altered skin integrity presented, registered staff would assess the area

and implement wound treatment and interventions to promote healing. The Inspector reviewed resident #002's progress notes and assessments with the DOC who indicated that it did not appear as though any assessment or intervention was done until four days after the altered skin integrity had been brought forth to staff by the SDM. The DOC indicated that staff should have assessed the area of altered skin integrity when they were first made aware of it, by the SDM. (638) [s. 50. (2) (b) (i)] (627)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint was submitted to the Director where the complainant indicated that resident #002 had developed a condition which required intervention. Please refer to WN #1 for further details.

Inspector #638 reviewed resident #002's health care records and identified in the eMAR a directive to "complete weekly wound note/assessment for each altered skin integrity area". The Inspector identified in the eMAR three dates whereby, it was indicated that a weekly wound assessment had been completed, by a check mark or a "9". The inspector reviewed resident #002's health care records and could not identify a weekly wound assessment for the first date that was marked as completed. For the second date marked as completed, the Inspector could only identify a progress notes which indicated that there was some confusion regarding the resident's altered skin integrity treatment. For the third date, a "9" was documented which indicated that a progress note had been completed; the Inspector was unable to identify the progress note.

The Inspector could only identify a completed assessment for the resident's altered skin integrity on one date, which was two days after it had been documented that a weekly wound assessment had been completed.

During an interview with Inspector #638, staff member #112 indicated that the residents who had areas of altered skin integrity were assessed at least weekly. The assessment would be completed and the record kept in the resident assessments tab, in PCC. Staff member #112 indicated that this monitoring

would be ongoing until the issue was resolved.

The home's policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program" last revised October 17, 2018, indicated that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #638 interviewed the DOC, who indicated that areas of altered skin integrity were monitored weekly and that the home implemented a process where they utilized an electronic device which photographed and measured the resident's wound. The DOC indicated that these assessments were documented in PCC. The Inspector reviewed the aforementioned dates with the DOC, with regards to weekly wound assessment. The DOC acknowledged that for the first date, no assessment had been completed, although it was documented as completed. For a later date, the DOC stated that although a wound assessment had been opened, the information had not been entered in the wound assessments.
[s. 50. (2) (b) (iv)]
(638)

3. A complaint was submitted to the Director regarding wound care for resident #004. Please see WN #2, item #3 and WN #6, item #1, for details.

Inspector #627 reviewed the resident's health care records and noted that upon admission, the resident had an assessment completed for multiple areas of altered skin integrity.

The Inspector was unable to find any follow up assessments for the multiple areas of altered skin integrity.

Inspector #627 reviewed the home's policy titled "Resident Rights, Care and Services-Required Program", last revised October 17, 2018, which indicated that "a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will have a weekly Skin and Wound Module through Point Click Care by use of IPOD, you must save and lock the "Skin and Wound Module" assessment and all documentation was generated

into a weekly wound progress note.

Inspector #627 conducted separate interviews with four staff members who stated that when a resident had a skin integrity issue, the wound care orders were added to the medication and treatment administration record (eMAR/eTAR) and a wound assessment was to be done weekly. The registered staff members acknowledged that resident #004's wounds had not been reassessed the following week.

During an interview with Inspector #627, the Co-DOC acknowledged that weekly wound assessments were to be completed with every resident who exhibited altered skin integrity. [s. 50. (2) (b) (iv)]
(627)

4. Inspector #638 reviewed resident #010's health care records and identified in the eMAR, a directive to complete a "Weekly Ipod (wound) assessment" of areas of altered skin integrity, on a specified day of the week. Upon reviewing the eMAR, the Inspector identified that the staff had documented their assessments as completed on three specific dates.

The Inspector reviewed the progress notes and assessments in the electronic records for the aforementioned dates and could only identify, for the completed assessment for a specific date, a late entry progress note which indicated "Assessment: [of wound] and no new signs of infections or inflammation were observed". The Inspector was unable to identify any further assessments for each of the areas of altered skin integrity, using a clinically appropriate skin and wound assessment tool. The Inspector also noted that the staff member had created this notation nine days after the care had been provided.

During an interview with Inspector #638, staff member #134 indicated that they could not recall this specific notation, however, management may have directed them to go back and complete the note. The Inspector inquired what tools they would use to complete an assessment on an area of altered skin integrity. The staff member indicated that they had an electronic device that could be used to photograph the area and complete an assessment, but if there were no significant changes they may just leave a short message on the status.

The DOC and Inspector #638 reviewed resident #010's electronic health care records and progress notes. Upon reviewing the progress note assessment, the DOC indicated that it was not a comprehensive assessment of resident #010's altered skin integrity and that staff should have used the electronic device to complete the assessment or use the progress note template for assessments instead of a general progress note.

During an interview with Inspector #638, the previous Administrator indicated that they had reviewed this incident and identified that staff member #134 had been exhausted and missed using the proper assessment note. The Administrator indicated that ideally staff would be using either the electronic device to complete assessments or using the wound note in the progress notes which was also a clinically appropriate assessment tool. [s. 50. (2) (b) (iv)]

The severity of the issue was determined to be a level 3 as there was actual harm or actual risk of harm to the residents. The scope of the issue was a level 3; widespread, as it was related to 3 of 3 residents reviewed. The home had a level 3 history of non-compliance which indicated one or more non-compliances, one of which is the same subsection or section being cited:
- WN, in October 2018, cited in inspection report 2018_657681_0025, and
- VPC in January 2017, cited in inspection report 2017_393606_0001. (638)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2019

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Order / Ordre :

The licensee must be compliant with section 229 (5), of the O.Reg. 79/10.

Specifically, the licensee shall, but not limited to:

1) Develop an in-service for all registered staff, to review wound infection continuum, signs and symptoms of infection, including colonization, critical colonization, infection, and sepsis. Ensure that all registered staff members attend. An attendance sheet will be provided to the Inspector upon request.
2) Develop and implement a system to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and the symptoms are recorded and that immediate action is taken as required.

Grounds / Motifs :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A complaint was submitted to the Director regarding altered skin integrity for resident #004. Please see WN #2, item #3, WN #4, item #3, and WN #6, item 1, for details.

Inspector #627 reviewed resident #004's heath care records and noted resident

#004 had a skin assessment completed upon their admission, for areas of altered skin integrity. The Inspector was unable to locate any further assessments of resident #004's areas of altered skin integrity. The Inspector also identified, in the "vitals tab" in PCC, that the resident had some abnormal vital signs since their admission.

Inspector #627 reviewed the home's policy titled, "Infection Control- Infection prevention and Control Surveillance Policy", last revised January 23, 2019, which indicated that the Registered Staff were to monitor for any change in condition, including signs and symptoms of infection, document in progress notes, using the infection note label, regarding the presence or absence of symptoms. On every shift, for those residents with infection or suspected infection, document in the progress notes, regarding the presence or absence of symptoms.

Inspector #627 interviewed staff member #129 who stated that when a resident exhibited certain symptoms of infection, they were to be monitored every shift. Staff member #129 stated that "this was what should have happened and obviously had not happened, staff should have been monitoring the resident".

Inspector #627 interviewed staff member #128 who stated that upon admission, a resident's vitals should be monitored for 72 hours. If the resident was identified as having abnormal vital signs, staff should have continued to monitor resident #004 every shift, the physician should have been informed as there was "something going on".

Inspector #627 interviewed the DOC who stated that when a resident had signs of infection, the physician should be called, the resident should be monitored, and the findings documented in progress notes, on every shift, and communicated to the oncoming staff and management, so the resident can get the proper care. The DOC acknowledged this was not done for resident #004. [s. 229. (5) (a)]

The severity of the issue was determined to be a level 3 as there was actual harm or actual risk of harm to the residents. The scope of the issue was a level 1 as it was isolated to one resident. The home had a level 2 history of noncompliance with previous non-compliance to a different subsection. (627)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 20, 2019

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 : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

The licensee must be compliant with section 19 (1), of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that all residents are protected from abuse by anyone, and from neglect by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone, and from neglect by the licensee or staff.

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

1) A complaint was submitted to the Director regarding altered skin care for resident #004. The complaint identified that resident #004 was admitted to the home and had a significant change in their health status because the home failed to provide medication or physician involvement.

Inspector #627 interviewed the complainant who stated that they had met with the home upon admission of resident #004 and discussed resident #004's medical condition. The complainant was informed by the home that the resident's medical condition was extremely serious. The complainant stated that they had asked if resident #004 needed a specific intervention or to go to the hospital for care of the medical condition and were told that "the home had experts who could provide better care than the resident would receive in the hospital and, if the resident went to the hospital, they would probably come back in worst condition". The complainant stated that they figured "they (the home)

knew what they were doing". The complainant became very emotional and further stated "I just don't know how Leacock didn't recognize it was that bad and try to do something about it." The complainant further stated that upon admission to the Emergency Department at the hospital, the physician had been very clear of the gravity of resident $004's medical condition.

Inspector #627 reviewed resident #004's medical health care records and noted resident #004 had a specific type of assessment completed, upon their admission. The Inspector was unable to locate any further assessments of resident #004's medical condition. The Inspector also identified, in the "vitals tab" in PCC that the resident had an abnormal vital sing which was documented on for three days.

The Inspector could not identify any other documented vital signs for resident #004 five days later, whereby the resident's abnormal vital sign was now within the norm.

A further review of resident #004's progress notes, by Inspector #627 during the review period, established a timeline of the resident's progressive deterioration.

During separate interviews with PA #117, NP #121, Physicians #131 and #132, they stated to Inspector #627 that they had not been made aware of resident #004 having an abnormal vital sign on the day of their admission and resident #004 deteriorating health status.

Inspector #627 interviewed the DOC who stated that if resident developed a specific abnormal vital sign, the nurse should complete and document an assessment. The DOC stated that if the abnormal vital sign remained after a specific intervention had been administered, the physician should be called, the oncoming shift should be made aware, as well as management on the floor. They stated that if the staff were unsure of what to do, they could reach out to management for advice. The DOC stated that staff should have kept monitoring the resident's vitals past the mandatory three days after their admission since the resident had an abnormal vital sign, and this had not been done.

Further non compliance was also identified under:
- Section (s.) 20 (1), of the Long-Term Care Homes Act, 2007; failure to comply

with the home's policy prevention of abuse and neglect policy titled "Resident Rights, Care and Services – Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019;
- S. 50 (2) (b) (iv), of the Ontario Regulation (O.Reg.) 79/10; failure to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and,
- S. 229 (5) (a) of the O. Reg 79/10; failure to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

2) A complaint was submitted to the Director which outlined an alleged incident of resident to resident abuse. The complaint indicated that they had been made aware of an incident whereby resident #011 had been abused on a specific date, and that the home was not following their own abuse policy.

Inspector #627 interviewed the complainant, who was resident #011's enacted SDM. The complainant stated that they had received a telephone call from an RN, on a specific date, who had informed them of the alleged incident of abuse, and that they (the RN) would be reporting the incident to the Co-DOC. The complainant stated that they had called early morning, and at the end of the day when their call had not been returned, at which time they reached the Co-DOC. The complainant stated that they had been told by the Co-DOC that they had not interviewed resident #011 or called the police as the resident had "seemed fine". When the complainant inquired as to why the home's abuse policy was not being followed, the Co-DOC had told them (complainant) that the information given in the admission package was not the process that was followed in the home as they had a new internal process that the home followed. The complainant stated that they had asked for a report of the investigation when it was completed and had been told that they (Co-DOC) were not required to do this, however, they (Co-DOC) would call them in four days. The complainant told Inspector #627 that they felt the home was minimizing the incident, the home refused to call the police and that the complainant feared for resident #011's safety.

Inspector #627 interviewed resident #011 a specific number of days after the incident. During the interview, resident #011's eyes became wide open when

Inspector #627 asked if there had been an incident, and they indicated "yes", when asked if they recalled the incident. Resident #011 demonstrated to the Inspector what had occurred to them, and indicated that they were fearful this would occur again. The resident indicated "no", when the Inspector inquired if anyone had discussed the incident with them.

Inspectors #638 and #627 interviewed staff member #128 who stated that they were present in the home when the incident between resident #011 and resident #012 occurred. Staff member #128 reported that resident #012 had demonstrated a specific type of responsive behaviour towards resident #011. Staff member #128 stated that they had directed staff to interview the residents and to call them to inform and to monitor the residents to see if they were upset, as they may have to report the incident to MOH and the OPP. Staff member #128 further stated that they had not received a call back, nor did they follow up with staff members until two days later. Staff member #128 acknowledged that they had not attempted to interview resident #011 and #012. Staff member #128 stated that they were unsure why there had been no documentation of the assessments in the resident's charts. Staff member #128 stated that they had received a call from resident #011's SDM who wanted to know if they had completed an investigation and called the police. Staff member #128 informed resident #011's SDM that they would call the police, however, they were directed by the previous Administrator not call the police, who wanted further investigation into the incident as they felt the incident should not be reported. Staff member #128 further stated that they had interviewed resident #011 five days after the incident, and that resident #011 had communicated to them that they had negative feelings of the incident.

Inspector #638 and #627 interviewed the DOC who stated that the residents should have been interviewed, a report should have been made the MOH and the police should have been called. The DOC further stated that they had to follow the [previous] Administrator's directives.

Inspector #638 and #627 interviewed the previous Administrator who stated that they had felt the incident was not abuse. The previous Administrator stated that "the resident had no problem with it, until you (Inspector #627) had spoken to her", at which time resident #011 had reported that they had remained with negative feelings regarding the incident. The previous Administrator stated that

they had then reported the incident to the Ministry and had called the police at that time, five days after the incident had occured.

Further non compliance was also identified under:
- S. 20 (1), of the LTCHA, 2007; failure to comply with the home's policy prevention of abuse and neglect policy titled "Resident Rights, Care and Services – Abuse- Zero Tolerance Policy for Resident Abuse and Neglect", last revised April 25, 2019;
- S. 24 (1), of the Long-Term Care Homes Act, 2007; failure to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.
- S. 231 (b) of the O. Reg 79/10; failure to ensure that the resident's written record was kept up to date, at all times;
- S. 98 of the O. Reg 79/10; failure to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence; and,
- S. 6. (10) (b), of the LTCHA, 2007, cited in Follow up inspection report, # 2019_752627_0015; failure to ensure that resident #012 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, or care set out in the plan was no longer necessary. [s. 19.]

The severity of the issue was determined to be a level 3 as there was actual harm or actual risk of harm to the resident. The scope of the issue was a level 2, pattern as it related to two of three residents reviewed. The home had a level 3 history, which indicated one or more non-compliances which were the same section or subsection being cited:
- Compliance Order (CO), on June 21, 2017, cited in inspection report #2017_646618_0011 with a compliance due date of September 29, 2017.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 25, 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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 25th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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