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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2018; Feb 6, 2019	2018_543561_0016	023251-18	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

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

DARIA TRZOS (561), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2018 and October 1, 2, 3, 2018.

The following Critical Incident System intake was inspected concurrently with this RQI:
Log # 016406-18, CIS#2570-000010-18
PLEASE NOTE: Non compliance identified in the CI inspection log number 016406-18, related to O. Reg 79/10, s. 8(1)(b) has been issued as a VPC in this RQI report.

The following Complaint intake was inspected during this RQI:
Log # 005152-18
PLEASE NOTE: Non compliance identified in a Complaint Inspection log number 005152-18 related to LTCHA, s. 6(4) and s. 6(5) have been issued in this report as a VPC.
The following additional Complaints and Critical Incidents were inspected concurrently with this Resident Quality Inspection (RQI):

Complaint Inspections:
022621-17 – related to multiple care areas,
019697-17 – related to falls management,
011543-17 - related to multiple care areas,
008853-17 – related to medication administration,
022283-17 – related to refusal of admission,
025203-18 – related to allegation of financial abuse,

Critical Incidents System (CIS) Inspections:
006623-17, CIS # 2570-000008-17 - related to allegation of sexual abuse,
011415-17, CIS # 2570-000010-17 - related to allegation of sexual abuse,
013307-17, CIS # 2570-000011-17 - related to allegation of sexual abuse,
017748-17, CIS # 2570-000016-17 - related to allegation of sexual abuse,
018619-17, CIS # 2570-000017-17 - related to allegation of sexual abuse,
018372-17, CIS # 2570-000018-17 - related to allegation of sexual abuse,
017444-17, CIS # 2570-000015-17 - related to falls,
015867-17, CIS # 2570-000013-17 - related to falls,
019748-17, CIS # 2570-000019-17 - related to falls,
023957-17, CIS # 2570-000024-17 - related to falls,
008319-18, CIS # 2570-000006-18 - related to falls,
004334-18, CIS # 2570-000003-18 - related to unexpected death,
006546-18, CIS # 2570-000005-18 - related to allegation of sexual abuse,
026096-18, CIS # 2570-000012-18 - related to infection prevention and control,
026617-18, CIS # 2570-000015-18 - related to allegation of sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Relation Coordinator, Director of Environmental Services, Resident Assessment Instrument (RAI) Coordinator, Unit Scheduling Coordinator, Registered Dietitian

(RD), Office Manager, Placement Coordinator (LHIN), Behaviour Supports Ontario (BSO) Nurse, Skin and Wound Care Nurse, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, President of the Resident Council, President of the Family Council, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

A) A review of the Critical Incident System (CIS) submitted to the Director, identified resident #013 sustained an injury and was taken to hospital which resulted in a significant change in the resident's health status after being transferred with a device.

Review of the plan of care identified, resident #013 was being transferred with a device on an identified date with PSW #118 and PSW #134.

During an interview with PSW #118, stated that during transfer the resident slid off the device as it was not properly applied. Resident was assisted by PSWs to the floor. At the time of the assessment by the RN #107 no injuries were noted. PSW #118 stated the resident did not complain of any pain at the time of the incident.

Review of the progress notes indicated the resident started to complain of increase pain several hours later. The resident was assessed by the Nurse Practitioner and ordered a test which showed that resident sustained an injury that required treatment at the hospital.

Interview with the Director of Care (DOC) verified that the transfer device was incorrectly applied and confirmed that PSW staff #118 and #134 used unsafe transferring techniques when assisting resident #013.

This area of non-compliance was identified during a CIS Inspection #015867-17, conducted concurrently with the RQI.

B) Review of a Complaint Inspection identified concerns related to transfers causing injuries to resident #020.

A transfer assessment completed on an identified date, noted that the resident was to be transferred with an identified device. Review of the plan of care identified that the resident had an identified condition and a specific procedure and treatment was required during transfers to prevent injuries.

On an identified date, LTCH Inspector #528, observed transfer of resident #020 using a device. During the transfer, the procedure and treatment was not applied as specified in the plan of care.

In an interview, PSW #150 stated that resident #020 had a condition and required staff assistance and treatment during transfers. PSW #150 also stated that the treatment

during the transfer observed by the LTCH Inspector should have been applied.

In an interview, the ADOC acknowledged that, due to the resident's condition, staff should have transferred the resident using a technique to prevent injury ensuring the treatment was applied.

During the transfer of resident #020 on an identified date, the staff were not observed using safe transferring techniques to ensure that the injury was prevented, as required in their plan of care. (528)

This area of non-compliance was identified during a Complaint Inspection log #011543-17, completed concurrently with the RQI.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

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

A Complaint submitted to the Director, identified a concern related to staff not completing safe transfers.

A progress note on an identified date, revealed that the staff were to ensure the specific technique was applied during transfer to prevent injury, which was identified as a cause of frequent altered skin integrity.
The written care plan for resident #020 identified that the resident had a history of an identified condition and required a device to be used when being transferred. The written care plan also noted that the resident had recurrent altered skin integrity; however, did not include an intervention directing staff what to do during transfers.

Interview with the ADOC confirmed that the resident required staff to apply a technique during transfer to prevent injuries but was not included in the written care plan.
Interview with the ED on an identified date in 2019, confirmed the written care plan did not provide clear directions to staff, related to an identified intervention to be used during transfers. (528)

This area of non-compliance was identified during a Complaint Inspection log #011543-17, conducted concurrently with the RQI.

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

The Ministry of Health and Long Term Care, received a complaint, related to neglect from a resident. According to the complainant, the home failed to assess the resident related to identified health conditions.

A) Review of the medical record revealed that resident #018 was admitted to the home on an identified date in 2018.

i) Review of the Minimum Data Set (MDS) Home Care Assessment, indicated in 'Section Notes' that the resident had a health condition and was no longer able to manage their own activities of daily living, and required ongoing medical treatment of symptoms related the health conditions, altered skin integrity and assistance with daily activities.

ii) Although the above assessments indicated that the resident had health instability, the Resident Assessment Protocol Summary (RAPS) was not reflective of the above assessments and indicated that an identified test score identified the resident to be at a specific score.

iii) The Canadian Institute for Health Information document 'Describing Outcome Scales (RAI-MDS 2.0)', last revised in 1999, described the scale of the identified test which detects frailty and health instability and was designed to identify residents at risk of serious decline. The nine factors included: decline in cognition, decline in activities of daily living (ADL), dehydration, edema, shortness of breath, vomiting, end-stage disease, weight loss, and leaving food uneaten. Scoring was zero to five and a higher number indicated higher levels of medical complexity and were associated with adverse outcomes, such as mortality, hospitalization, pain, caregiver stress and poor self-rated health.

iv) Interview with the DOC confirmed that the score in the RAPS for resident #018 was inconsistent with the MDS Home Care Assessment, and confirmed that the resident's score did not reflect the resident's decline in activity and cognitive impairment documented by staff.

B) Review of admission assessments on an identified date in 2018, electronic documentation, and the progress notes, confirmed that the resident #018 had multiple areas of altered skin integrity requiring wound care. However, the Resident Assessment Protocol Summary (RAPS) indicated that the resident had a low risk of a pressure ulcer risk scale (PURS). Interview with the DOC confirmed that the RAPS from March 2018, and documentation from direct care staff was inconsistent, related to a PURS score. (528)

This area of non-compliance was identified during a complaint inspection log #005152-18, conducted concurrently with this RQI.

C) A review of a Complaint submitted to the Director on an identified date in 2017, identified a concern related to the home's management of falls for resident #031.

Review of the Post Fall Huddle Assessment, identified that resident #031 had a fall on two different dates in 2017, with no injuries. Review of the Minimum Data Set (MDS) assessment identified the resident did not have a fall or a specific injury.

In an interview with the RAI Coordinator, they verified that the resident had fallen in the past 30 days and in the past 31 to 180 days. They confirmed the Post Fall Huddle Assessment and the MDS assessment were not integrated and consistent with each other. (581)

This area of non-compliance was identified during a Complaint Inspection log #019697-17, conducted concurrently with the RQI.

3. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A) The Ministry of Health and Long Term Care received a complaint on an identified date in 2017, indicating that the family requested to have a medication administered to resident #021 on an identified date at a specified time prior to an outside appointment. In an interview with the LTCH Inspector #561, the complainant stated that the home failed to listen to the request and did not administer the medication as requested.

Clinical record review indicated that the family requested the registered staff to administer a medication at a specific time prior to an outside appointment and that the Nurse Practitioner would inform the physician to write an order for that time. The physician orders were reviewed and the order for the medication was written for 1000 hours. The progress note on an identified date indicated that the family had a discussion with the home and was upset that the resident received the medication at time not as requested. The Electronic Medication Administration Record (EMAR) was reviewed and indicated that the resident received the medication at 1000 hours.

The registered staff #152 was interviewed and indicated that they recall writing the progress note after they had discussed the family's request for administration of the medication for the specific time. The registered staff stated that they verbally communicated this request with the oncoming staff and also documented this in progress notes and the 24 hours report. They were not aware of why this was not communicated to the physician.

The licensee failed to ensure that resident #021's substitute decision maker was given an opportunity to participate in the development and implementation of the plan of care. (561)

This area of non-compliance was identified during a Complaint Inspection log #008853-17, conducted concurrently with the RQI.

B) Review of a Complaint Inspection related to concerns that Substitute Decision Makers (SDMs) were not being notified of changes in treatment and care for residents.

The plan of care for resident #020 identified that the resident had a cognitive status and had SDMs for care and finances.
Review of digital prescriber's order forms and nursing progress notes for the resident, did not include documentation that the SDMs were notified of changes in the resident's care for the following instances:
a. New areas of altered skin integrity on multiple days
b. Diagnostic testing or results on multiple days
c. Change in wound care orders on multiple days
d. Change in diet orders on an identified date

In an interview with the ADOC, they acknowledged that the home failed to notify the SDMs of resident #020 when their treatment or health status changed, including but not limited to, medication orders, diagnostic testing, wound care, and change in diet listed above.

This area of non-compliance was identified during a Complaint Inspection log #011543-17, completed concurrently with the RQI.

C) The Ministry of Health and Long Term Care, received a complaint on an identified date in 2018, related to neglect of a resident. A follow up call was placed to the complainant during the course of the inspection, at which time, they identified that the home failed to notify them of changes in the resident's plan of care.

The home's policy 'Change of status - Notification of POA/Family:VIII-B-10.20', last revised January 2015, outlined the following circumstances required notification of the resident and or Power of Attorney (POA) for Care or designate including but not limited to:
a. change in resident's health status
b. when a resident has been transferred to hospital in an emergency situation
c. if a resident has an appointment external to the home
d. for the approval of non-funded services

e. to obtain consent for care and treatment, if required
f. release of information
g. to organize an inter-professional care conference

Review of the medical records for resident #018 revealed that in 2018, they were admitted to the home with multiple diagnosis' contributing to a cognitive status and had SDMs.
Review of the plan of care did not include documentation that the SDMs were notified of changes in treatment as follows:
a. New medications order on multiple occasions
b. Change in diet order

Interview with the ADOC confirmed that the home failed to obtain consent from the SDMs of resident #018 for changes to the plan of care. As a result, the SDMs were not provided the opportunity to full participate in the development and implementation of the plan of care (528).

This area of non-compliance was identified during a complaint inspection log #005152-18, conducted concurrently with this RQI. [s. 6. (5)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

Numerous CIS reports were submitted to the Director by the home in the year 2017 related to resident #008 abusing residents #009, #011 and #012.
The clinical record review indicated that after the first incident when resident #008 demonstrated identified responsive behaviour towards resident #009, the home implemented identified interventions to prevent these incidents. Resident #008 again demonstrated the identified behaviour towards resident #009. The home implemented another intervention. The clinical records indicated that resident #008 continued to have the identified behaviour and this time towards resident #011 and resident #012 on multiple occasions.

Interviews with PSW #109 and #147 during this inspection, identified that resident #008 had the identified behaviours and they had to constantly monitor resident #008. They confirmed that interventions were in place.

The BSO Nurse was interviewed and stated that resident #008 had the identified

behaviours in 2017. They implemented the intervention to monitor the resident. The BSO stated that it was impossible to monitor resident #008 at all times, and they did manage to have incidents numerous times after the intervention was implemented.

The DOC and the ED were interviewed and indicated that it was not always possible to monitor resident #008 to prevent the behaviour from recurring.
The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

This area of non-compliance was identified during CIS Inspections, log #006623-17, #011415-17, #017748-17, #018372-17, and #018619-17, conducted concurrently during the RQI. [s. 6. (10) (c)]

5. The licensee failed to ensure that when the plan of care was being revised because the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan.

A review of a Complaint submitted to the Director in 2017, identified a concern related to the licensee's management of falls for resident #031.
According to the clinical health record, the resident had multiple unwitnessed falls in 2017. One of the falls resulted in injury.
Review of the clinical record identified that an intervention was implemented on an identified date in 2017 and another intervention not until numerous falls occurred.
The DOC and ADOC confirmed that when the plan of care was being revised, different approaches were not considered or implemented to manage the resident's falls when resident #031 continued to fall with one fall resulting in an injury.

This area of non-compliance was identified during a Complaint Inspection log #019697-17, conducted concurrently with the RQI. [s. 6. (11) (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 care set out in the plan of care is provided to the resident as specified in the plan, to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, and to ensure that when the plan of care is being revised because the care set out in the plan has not been effective, that different approaches are considered in the revision of the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system it was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with Ontario Regulation 79/10, section 68, which required an organized program of nutrition care and dietary services, including the development and implementation of policies and procedures.

The home's "Monitoring of Resident Weights Policy VII-G-20.80 (current revision date

April 2016) directed PSW staff to immediately reweigh any resident with a weight variance (from previous month) of two kilograms (kg), report variances to registered staff immediately and the registered staff ensure that monthly weights or re-weighs were documented in the weights and vitals section of the electronic record by the 10th of every month.

On an identified date in 2017, resident #001 had significant weight gain of 10% over 3 months. Staff #102 indicated they would usually review the weights and identify significant weight loss or gain on a monthly basis and request re-weighs. No re-weigh request was completed for resident #001, which was identified by staff #012, and acknowledged by the DOC.

The licensee failed to ensure that the home complied with the Monitoring of Resident Weight Policy. (632) [s. 8. (1) (a),s. 8. (1) (b)]

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

The Long Term Care Homes Act, 2007, Ontario Regulation 79/10, r. 114 (2) indicates that the licensee must ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The policy titled "Shift Change Monitored Drug Count", policy 6-6, revised Feb 2017, indicated that two staff (leaving and arriving) together to count the actual quantity of medications remaining, record the date, time, quantity of medication and sign in the appropriate spaces on the "Shift Change Monitored Medication Count" form.

On an identified date in 2018, during a medication pass, LTCH Inspector #561 reviewed the binder for the Shift Change Monitored Drug Count and identified that the oncoming registered staff did not sign the narcotic count sheet, only the nurse leaving signed the narcotic count sheet for that day. Registered staff #116 was interviewed and stated that they counted all the narcotics with the nurse leaving; however, forgot to sign the Shift Change Monitored Drug Count form.

On an identified date in 2018, the LTCH Inspector #561 reviewed the binder for the Shift Change Monitored Drug Count forms at approximately 0915 hours and identified that there were missing signatures for the count of narcotics that morning by the oncoming

nurse. Registered staff #106 was interviewed and stated that the process in the home was to count at shift change with the leaving nurse and sign the Shift Change Monitored Drug Count form after the count. Registered staff #106 stated that they had counted the narcotics that morning and had not signed the forms yet. LTCH Inspector also identified that the Shift Change Monitored Drug Count forms had two other times with missing signatures.

In an interview, the ADOC indicated that the process in the home was to count together and sign the Shift Change Monitored Drug Count form together by the leaving and starting nurse. The ADOC indicated that the home's policy related to Shift Change Monitored Drug Count was not complied with.

B) The Long Term Care Homes Act, 2007, Ontario Regulation 79/10, r. 48, states that ever licensee shall ensure that a falls prevention and management program is developed and implemented to reduce the incidence of falls and the risk of injury.

The home's policy titled "Falls Prevention", policy number VII-G-30.00, revised January 2015, identified that post fall assessment, registered staff were not to move resident if there is suspicion or evidence of injury. The physician should be contacted and/or arrange for immediate transfer to the hospital.

A CIS was submitted to the Director on an identified date in 2018, related to a fall of resident #014 whereby the resident sustained an injury and was transferred to hospital. The CIS indicated that resident passed away in the hospital. The home's investigation notes were reviewed by LTCH Inspector #561 and stated that after the resident fell, registered staff #135 assessed them and observed evidence of injury. After assessment, two PSWs and the registered staff transferred resident #014 from the floor to their bed using a device.

During the interview with the registered staff #135, it was identified that the registered staff assessed the resident and observed that there was evidence of injury. The registered staff assisted two PSWs to transfer the resident from the floor to bed using a device. When LTCH Inspector #561 questioned the registered staff about the home's policy, they had stated that they should not have moved the resident from the floor until ambulance arrived.

The DOC was interviewed and acknowledged the home's policy stated that if there is a suspected injury after the fall, a resident should not be moved until the physician is

notified and arrangement should be made to transfer the resident to the hospital.

The licensee failed to ensure that the home's "Falls Prevention" policy was complied with.

This area of non-compliance was identified during a CIS Inspection, log # 016406-18, conducted concurrently with this RQI. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect

that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A) Review of a Complaint identified concerns related to accommodation charges.

In 2015, resident #022 was admitted to the home and the plan of care identified that the resident had Substitute Decision Makers (SDMs) for care and finances.
Review of the resident #022's monthly accommodation charge and annual income from an identified period of time, indicated that the monthly accommodation charge was based on the resident's Notice of Assessment.

A Transaction Report for an identified period, revealed that there was an outstanding balance for resident #022's billing account.
Letters had been sent to the SDM requesting payment, noting an outstanding balance.

In an interview with a third party, it was reported that the resident had an outstanding bill.
Interview with the Office Manager, identified that the home suspected abuse and therefore started a "profile" in 2016.
Interview with the Office Manager and ED revealed that a Critical Incident Report had not been submitted to the MOHLTC identifying suspected abuse, as required in the home's policy "Prevention of Abuse and Neglect of a Resident", policy number VII-G-10.00, revised January 2015. (528)

This area of non-compliance was identified during a Complaint Log #025203-18, conducted concurrently with the RQI.

B) A CIS was submitted to the Director on an identified date in 2017, related to a witnessed abuse of resident #009 by resident #010.

The clinical record review indicated that the incident was not reported to the Director immediately.

The home's policy titled "Prevention of Abuse & Neglect of a Resident", policy number VII-G-10.00, revised January 2015, indicated that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to

the Director of MOHLTC and the Executive Director.

In an interview with the ADOC, they stated that the home did not submit the CI report immediately to the Director.

The licensee failed to ensure that the alleged abuse of a resident #010 towards resident #009 was reported to the Director immediately.

This area of non-compliance was identified during a CIS Log #013307-17, conducted concurrently with the RQI.

C) A CI was submitted to the Director on an identified date in 2017, related to a witnessed abuse of resident #009 by resident #008. The clinical record review indicated that the incident was not reported to the Director immediately.

D) A CI was submitted to the Director on an identified date in 2017, related to a witnessed abuse of resident #012 by resident #008. The clinical record review indicated that the incident occurred on an identified date in 2017; however, the CI had the wrong date of occurrence.

The home's policy titled "Prevention of Abuse & Neglect of a Resident", policy number VII-G-10.00, revised January 2015, indicated that all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director.

In an interview with the DOC, they stated that the home did not submit the CIS for resident #008 immediately to the Director.

This area of non-compliance was identified during CIS Inspections log #006623-17 and #018619-17, conducted concurrently with the RQI. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur should immediately report the suspicion and the information upon which it was 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., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A review of a complaint submitted to the MOHLTC in2017, indicated some concerns about weight loss for resident #019, who had multiple health conditions. Review of Weights and Vitals Summary indicated that resident #019 had a significant weight loss of more than 7.5% over three months during a period of time in 2017. A review of the resident's Meals and Snacks interventions recorded in Documentation Survey Report v2

indicated that there were no meals and snacks records on multiple days in 2017.

In an interview, PSW #110, #119, #123 were not able to recall if resident had their meals or snacks. The RAI Co-ordinator indicated that based on their investigation staff #136 and staff #121 forgot to document food intake for resident #019 on multiple days in 2017 on the electronic records.

The licensee did not ensure that resident's meal intakes were documented by staff. (632)

This area of non-compliance was identified during a Complaint Inspection log #022621-17, conducted concurrently with the RQI.

B) The plan of care for resident #031 directed front line staff to apply a device as an intervention for falls. Review of the Documentation Survey Report identified that the PSW staff were not documenting when the device was applied.

The RAI Coordinator confirmed in an interview, that staff were not able to document the application of the device and stated the task should have been customized to include this intervention on the electronic records as the resident was at high risk for falls and had multiple documented falls.

The RAI Coordinator confirmed that not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

This area of non-compliance was identified during a Complaint Inspection log #019697-17, conducted concurrently with the RQI. (581)

C) Numerous CIS reports were submitted to the Director by the home in 2017 related to resident #008 abusing residents #009, #011 and #012.

The clinical record review indicated that after the first incident in 2017 when resident #008 demonstrated an identified behaviour towards resident #009, the home implemented Dementia Observation System (DOS) monitoring. The resident had multiple incidents of the identified behaviour after the intervention. Resident #008 continued to be on DOS monitoring.

The DOS monitoring forms were reviewed and identified that there were several days

where the staff missed documentation of monitoring the resident on DOS forms.

The BSO Nurse was interviewed and stated that resident #008 had the identified behaviours in 2017 and was on DOS monitoring. They indicated that DOS was an important assessment of behaviours where they could analyze and see patterns of behaviours and based on that implement appropriate interventions. The BSO Nurse acknowledged that staff did not always document monitoring on the DOS form.

In an interview with the DOC and the ED, the DOC acknowledged that the staff did not always document monitoring on the DOS forms.

The licensee failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included documentation of resident's responses to the interventions.

This area of non-compliance was identified during CIS Inspections, log #006623-17, #011415-17, #017748-17, #018372-17, and #018619-17, conducted concurrently during the RQI. [s. 30. (2)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Findings/Faits saillants :

1. The licensee failed to ensure that the applicant's admission to the home was approved unless, (a) the home lacks the physical facilities necessary to meet the applicant's care

requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

A review of a Complaint identified concerns related to the refusal of a resident's admission into Fox Ridge Care Community.

A) On an identified date in 2017, the Local Health Integration Network (LHIN) applied for admission to Fox Ridge Care Community for applicant #023. A letter stated that the applicant's approval would be withheld because they did not have the resources to meet their needs. Specifically, that the applicant had been assessed as having an unsafe behaviour and the behaviour posed a high risk to the residents of the home.

An assessment completed by the Placement Coordinator, assessed the applicant to be independent; however, the applicant was noted to have been in support of an identified program, if required for admission.

An interview with the Resident Relations Coordinator (RCC), identified that the home was currently not accepting applicants with the identified behaviour, due to the number of residents with the identified behaviour already resided in the home.

Interview with the ED confirmed that the home was not accepting applicants with the identified behaviour due to the current resident population living at the home, the home was not following legislative requirements.

B) On an identified date in 2018, the LHIN applied for admission to Fox Ridge Care Community, for applicant #025. A letter stated that the applicant's approval would be withheld due the fact that the applicant had an identified behaviour and they could not accommodate any more residents with this behaviour.

An assessment indicated that the applicant no longer had a condition identified with the behaviour.

Interview with the ED confirmed that currently had residents with the identified behaviour. The ED acknowledged that by the home not admitting applicant with this behaviour, they were not following legislative requirements.

This area of non-compliance was identified during a Complaint Inspection log #022283-

17, conducted currently with this RQI. [s. 44.]

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 applicant's admission to the home is approved unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to the residents demonstrating responsive behaviours.

A) A CIS report was submitted to the MOHLTC in 2018, related to the incident of resident to resident alleged abuse. CIS Report indicated that resident #016 was sitting beside resident #017 and was demonstrating a responsive behaviour witnessed by staff #123.

A review of the clinical record identified that resident #016 and #017 had multiple health conditions and identified impairments.
Review of the most recent written plan of care for resident #016 indicated to redirect resident #016 away from specified residents. Resident #016 had a previous incident involving resident #017.

Staff #107 confirmed the intervention in place to prevent this incident from occurring.

The home failed to ensure that the strategy about redirecting resident #016 from specified residents, once they were beside the resident was implemented, which was acknowledged by the DOC. (632)

This area of non-compliance was identified during a CIS Inspection log #026617-18, conducted concurrently with the RQI.

B) A CIS report was submitted to the Director on an identified date in 2017, related to an incident of alleged abuse by resident #008 towards resident #009. Another CI was submitted to the Director in 2017, related to an incident of alleged abuse by resident #010 towards resident #009.

Interview with PSWs #147 and #109, identified that resident #009 had identified behaviours towards identified residents. They also stated that at times this was a trigger and may have initiated undesired behaviour.

The clinical records were reviewed and did not identify this behaviour in resident #009's written plan of care or progress notes. There were no interventions developed to address this behaviour.

In an interview with the BSO Nurse, they acknowledged that resident #009 had the behaviours with specified residents in 2017. They stated that interventions should have been developed to address this behaviour, such as redirection and monitoring. The BSO Nurse stated that the plan of care did not include this behaviour and did not list interventions to address it.

The licensee failed to ensure that strategies had been developed to respond to resident #009's demonstrated responsive behaviours.

This area of non-compliance was identified during CIS inspections log #006623-17,

#011415-17 and 013307-17, conducted concurrently during this RQI. [s. 53. (4) (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 for each resident demonstrating responsive behaviour, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: 6. That the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any

other time when necessary based on the resident's condition or circumstances.

Review of the plans of care for residents #003, #028 and #029 who required the use of a restraint did not identify that registered staff were documenting every eight hours that the residents' conditions were reassessed and that the effectiveness of the restraints were evaluated.

Resident #003 was observed with a restraint applied. Review of the plan of care identified the resident required a restraint for safety reasons and this was verified during an interview with PSW #109.

Resident #028 was observed on an identified date with a restraint being applied. Review of the plan of care identified the resident required a restraint for positioning related to a specific diagnosis. Interview with PSW #118 stated the resident had the restraint in place.

Resident #029 was observed on an identified date, with a restraint applied. Review of the plan of care identified the resident required a restraint for positioning and safety which was verified in an interview with PSW #120.

During an interview with RN #107, they stated registered staff did document every shift the effectiveness of the restraint in the electronic documentation system on an identified date in 2018, when there was a change in the home's electronic documentations system.

In an interview with RAI Coordinator, they stated that registered staff were to document the effectiveness of the restraint in the electronic documentation system; however, after reviewing the documentation they confirmed that the PSW staff were signing for the restraint evaluation since the home changed their documentation in July 2018, to one record.

The RAI Coordinator confirmed that resident #003, #028 and #029's conditions were not reassessed and the effectiveness of the restraint was not evaluated by registered nursing staff every eight hours or as needed from an identified date in July until October. [s. 110. (2) 6.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee failed to ensure that the following was documented: 7. Every

release of the device and all repositioning.

On an identified date in 2018, resident #003 was observed with a restraint applied. PSW #109 was observed releasing the restraint and repositioning the resident. Review of the plan of care identified that the resident required a restraint for their safety. The restraint documentation for releasing the restraint and repositioning the resident was reviewed and there was no documentation to indicate that the resident was released from the restraint as noted above.

The RAI Coordinator was interviewed and stated that PSW staff were to release all restraints every two hours or as needed; however, verified after they reviewed the electronic documentation there was no place for the PSW staff to document the task in the electronic documentation system. They stated that the PSW staff were only documenting when the restraint was applied, removed, safety checks, repositioning and when the restraint was not in use.

The RAI Coordinator confirmed that every release of the device was not documented for all resident's in the home that had a restraint device.[s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The home failed to ensure that staff participated in the implementation of the infection prevention and control program.

Review of a CIS was completed related to infection prevention and control.

"Routine Practices and Additional Precautions in All Health Care Settings ", dated November, 2012, published by Provincial Infectious Diseases Advisory Committee (PIDAC), identified routine administrative controls to prevent the spread of infection, including but not limited to; policies and procedures related to personal items not being shared.

The home's policy "Routine Practices", policy number IX-G-10.00, last revised January 2015, outlined that the consistent and appropriate use of Routine Practices by all staff with all resident encounters would lessen microbial transmission in the healthcare setting and reduce the need for Additional Precautions. In addition, the home's procedure "Personal Effects", policy number VII-C-10.10(b), dated January 2015, stated that "all personal items that are to be kept in a resident's room must be labeled with resident's name."

Review of CIS report, revealed that on an identified date in 2018, PSW #135 provided personal care to resident #044, using resident #045's personal care item.

Review of the investigation notes and interview with the ADOC, confirmed that, PSW #135 took an unlabeled personal care item from resident #044's dresser and used it on

resident #044. After personal care was completed, resident #045 suggested that it was their personal care item.

Interview with the ADOC revealed that the home was unable to determine who the item belonged to; however, confirmed that the item, and all other personal care items are not to be shared and should have been labeled.

Observation of the personal equipment of residents #044 and #045, included multiple care items that were not labeled.

Interview with PSW #123, who was not caring for the two residents, confirmed that the personal care items were unlabeled and therefore, they could not identify which items belonged to which resident.

Staff failed to participate in the implementation of the infection prevention and control program, related to the routine practice of labeling of personal care items for residents #044 and #045.

This area of non-compliance was identified during a CIS Inspection log #026096-18, conducted concurrently with the RQI. [s. 229. (4)]

2. The licensee failed to ensure that on every shift,
(a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms were recorded and that immediate action was taken as required.

A complaint was submitted to the Director related to concerns of an area of altered skin integrity and a condition change.

A) The plan of care for resident #020, identified that they had recurrent issues with altered skin integrity requiring interventions.

On an identified date in 2017, registered staff documented in the progress notes that the resident had a new altered skin integrity. Due to concerns from family, the wound was assessed and the resident was started on treatment.

Review of the plan of care did not include the symptom monitoring and documentation

every shift.

In an interview the ADOC acknowledged that the resident was prescribed treatment for a condition, and requirements of registered staff were to document the symptoms on the monthly surveillance record, as well as, monitor the resident for symptoms and document every shift in the progress notes.
In an interview with the ADOC, they identified that registered staff did not monitor and record the symptoms for resident #020 every shift, as required.

This area of non-compliance was identified during the Complaint Inspection log #011543-17, conducted concurrently with the RQI.

B) Review of Infection Surveillance Control Record and progress notes for resident #042 and #043, revealed that consistent monitoring and documentation were not completed following diagnosis and treatment of a condition.

The plan of care for resident #042 identified that they were prescribed treatment for a condition. Review of the plan of care did not include monitoring and documentation every shift, as required.

The plan of care for resident #043 identified that the resident was placed on treatment for a condition. Review of the plan of care did not include monitoring and documentation every shift, as required.

In an interview the ADOC, acknowledged that staff were not consistently monitoring and recording the resident's symptoms of infection every shift, as required by the home. [s. 229. (5)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of Prevention of Abuse and Neglect of a Resident Policy VII-G-10.00 (current revision January 2015) indicated in the investigation section that the Executive Director and /or Administrator or designate were to interview the resident, other residents, or persons who might have any knowledge of the situation.

A CIS was submitted to the Director on an identified date in 2018, related to the incident of resident #016 to resident #017 alleged abuse. CIS report indicated that resident #016 demonstrated a responsive behaviour towards resident #017 which was confirmed by staff #129. Review of clinical records did not contain any information that resident #016 or resident #017 were interviewed about the incident.
The DOC indicated that resident #016 and #017 were not interviewed after the incident occurred.

The home did not ensure that Prevention of Abuse and Neglect of a Resident Policy, policy number VII-G-10.00 was complied with.

This area of non-compliance was identified during a CIS Inspection log #006546-18, conducted concurrently with the RQI. [s. 20. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the changes and improvements resulting from the annual evaluation to determine the effectiveness of the policy to promote zero tolerance of abuse and neglect of residents and the date that the changes and improvements were implemented.

The annual evaluation of the program to promote zero tolerance of abuse and neglect of residents was reviewed by LTCH Inspector #561. The evaluation did not include the changes and improvements resulting from the annual evaluation to determine the effectiveness of the policy. The Executive Director was interviewed and stated that there were a number of changes that the home had implemented; however, those actions were not documented in the annual evaluation of the program.

The licensee failed to ensure that the changes and improvements made to determine the effectiveness of the abuse and neglect program were documented. [s. 99. (e)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

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

WN #13: 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 failed to ensure that the resident's written record was kept up to date at all time.

A CIS was submitted to the Director on an identified date in 2018, related to the incident of resident #016 to resident #017 alleged abuse. CI Report indicated that resident #016 demonstrated a responsive behaviour towards resident #017, which was confirmed by staff #129. Both residents had identified health condition and identified impairments.

Review of written plan of care for resident #017, indicated in behaviour problem focus that identified interventions were in place. In an interview, staff #149 indicated that Dementia Observation Scale (DOS) tracking was initiated for resident #017 after the incident occurred but no written record was kept. Review of progress notes, indicated that staff would be ensuring that resident #017 was watched and/or monitored for remainder of shift. ADOC indicated that no written record of DOS tracking was kept up to date for resident #017, which was acknowledged by the DOC.

The home did not ensure that resident #017's written record related to DOS tracking was kept by staff.

This area of non-compliance was identified during a CIS Inspection log #006546-18, conducted concurrently with the RQI. [s. 231. (b)]

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*

Issued on this 7th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2018_543561_0016
Log No. / No de registre :	023251-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 3, 2018; Feb 6, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fox Ridge Care Community 389 West Street, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Croley

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of O. Reg 79/10.

Specifically, the licensee must:
1. Ensure that PSW #118, #134 and #150 are trained on proper techniques when transferring all residents using the sit to stand mechanical lift including but not limited to the application of the leg straps and protecting resident's from receiving altered skin integrity from an improper transfer. This training should be included in the home's annual training.

Grounds / Motifs :

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

A) Review of a Complaint Inspection identified concerns related to transfers causing injuries to resident #020.

A transfer assessment completed on an identified date, noted that the resident was to be transferred with an identified device. Review of the plan of care identified that the resident had an identified condition and a specific procedure and treatment was required during transfers to prevent injuries.

On an identified date, LTCH Inspector #528, observed transfer of resident #020 using a device. During the transfer, the procedure and treatment was not applied as specified in the plan of care.

In an interview, PSW #150 stated that resident #020 had a condition and required staff assistance and treatment during transfers. PSW #150 also stated

that the treatment during the transfer observed by the LTCH Inspector should have been applied.

In an interview, the ADOC acknowledged that, due to the resident's condition, staff should have transferred the resident using a technique to prevent injury ensuring the treatment was applied.

During the transfer of resident #020 on an identified date, the staff were not observed using safe transferring techniques to ensure that the injury was prevented, as required in their plan of care. (528)

B) A review of the Critical Incident System (CIS) submitted to the Director, identified resident #013 sustained an injury and was taken to hospital which resulted in a significant change in the resident's health status after being transferred with a device.

Review of the plan of care identified, resident #013 was being transferred with a device on an identified date with PSW #118 and PSW #134.

During an interview with PSW #118, stated that during transfer the resident slid off the device as it was not properly applied. Resident was assisted by PSWs to the floor. At the time of the assessment by the RN #107 no injuries were noted. PSW #118 stated the resident did not complain of any pain at the time of the incident.

Review of the progress notes indicated the resident started to complain of increase pain several hours later. The resident was assessed by the Nurse Practitioner and ordered a test which showed that resident sustained an injury that required treatment at the hospital.

Interview with the Director of Care (DOC) verified that the transfer device was incorrectly applied and confirmed that PSW staff #118 and #134 used unsafe transferring techniques when assisting resident #013.

This area of non-compliance was identified during a CIS Inspection #015867-17, conducted concurrently with the RQI.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two residents out of three reviewed. The home had a level 2 history as they had previous unrelated non-compliance with the legislation. (581)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 3rd day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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