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 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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 21, 2016 | 2016_433625_0004 | 008869-14, 001605-15, 004521-15, 008247-15, 016479-15, 017103-15, 017279-15, 021991-15, 026144-15, 026390-15, 028606-15, 032064-15, 004434-16, 010671-16, 011384-16 | Complaint |

**Licensee/Titulaire de permis**

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

KATHERINE BARCA (625), JULIE KUORIKOSKI (621), SHEILA CLARK (617)

## 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): April 4th to 8th, 11th to 15th, 19th to 22nd and 25th to 29th, 2016.**

**A Critical Incident System Inspection was conducted concurrently with this inspection. For details, please refer to inspection #2016_433625_0005.**

**Logs completed during this inspection were:**
**- 008869-14 and 004434-16 related to complaints regarding trust accounts;**
**- 008247-15 related to a complaint regarding sufficient staff, continence care, and the Residents' Bill of Rights;**
**- 016479-15 related to a complaint regarding abuse;**
**- 017279-15 related to a complaint regarding admission criteria;**
**- 021991-15 related to a complaint regarding a sewer back-up;**
**- 028606-15 related to a complaint regarding a safe and secure home and Residents' Bill of Rights;**
**- 001605-15 related to a complaint regarding dining and snack services, continence care and bowel management supplies; personal support services related to bathing and sufficient staffing;**
**- 017103-15 related to a complaint regarding continence care, bed rail use, nutrition concerns, pain management, falls prevention and reporting and complaints;**
**- 026144-15 related to a complaint regarding personal support services related to bed time, plan of care concerns and Residents' Bill of Rights;**
**- 026390-15 related to a complaint regarding discharge criteria, grooming, personal items and responsive behaviours;**
**- 032064-15 related to a complaint regarding Residents' Bill of Rights and plan of care;**
**- 004521-15 related to a complaint regarding accommodation charges;**
**- 010671-16 related to a complaint regarding medication administration; and**
**- 011384-16 related to a complaint regarding infection prevention and control and Residents' Bill of Rights.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Directors of Care (DOCs), Associate Director of Care (ADOC), Case Manager (CM), Environmental Services Supervisor (ESS), Maintenance employees, Housekeeping employees, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PWSs), Resident Relations Coordinator (RRC)/Registered Social Services Worker, Education Coordinator, Office Manager, MediSystem Accounts Receivable Clerk, Head Technologist of the Toronto Public Health Lab's Enteric Laboratory, residents and family members.**

**The Inspectors also reviewed resident health care records, various home's policies**

**and procedures, employee training records, employee files, home's investigation files and maintenance records. Inspectors completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, home areas, meal services and conducted a tour of resident care areas.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Falls Prevention**
**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**
**Responsive Behaviours**
**Safe and Secure Home**
**Sufficient Staffing**
**Trust Accounts**

**During the course of this inspection, Non-Compliances were issued.**
- **17 WN(s)**
- **10 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A complaint was received by the Director related to staffing and the availability of staff to assist residents during meal service.

On April 13, 2016, Inspector #625 observed RPN#132 sitting beside resident #033 during the dinner meal. RPN #132 held an empty spoon in the air as they used their cellular phone. Inspector observed RPN #132 hold the empty spoon in the air, in front of the resident, for several minutes. Inspector #625 moved to stand in front of the table RPN #132 was seated at with resident #033. The RPN continued to use their cellular phone, while the resident waited for the RPN, until the Inspector spoke to the RPN.

On April 27, 2016 Inspector #625 observed RPN #133 in a nursing station using their cellular phone while resident #034 sat watching the RPN. The RPN was not interacting with the resident and continued to use their cellular phone for several minutes. When the Inspector questioned the RPN about cellular phone use in the home, they stated that

personal cellular phones were not to be used in the home and were not to be kept or used on the resident home areas.

During an interview on April 27, 2016 with Inspector #625, ADOC #122 stated that personal cellular phones should not be carried by staff at work. The ADOC stated that the use personal cellular phones while feeding residents, or on resident home areas in the presence of residents, were not acceptable practices. [s. 3. (1) 1.]

2. A complaint was received by the Director which identified that, on a specific date in the summer of 2015, resident #010 had been woken from their sleep in the early morning by a PSW who turned on the light, pulled back the blankets on the resident's bed and checked the resident for a specific observation. The complainant reported that the PSW then ordered the resident to get up and complete a specific activity of daily living (ADL).

A review of resident #010's health care record included two progress notes dated on a specific date in the summer of 2015. The notes indicated that the resident complained that a PSW entered their room at about 0500 hours, whipped the covers off of the residents and told them to get up and complete a specific activity of daily living (ADL). The notes indicated that the resident was tearful, reiterated the concern many times, stated that what had occurred had been embarrassing to the resident, and left the dining room stating they were too upset to eat. One note identified that the resident stated they did not require the staff to wake them up at night related to a specific ADL.

Inspector #621 reviewed a copy of the 24 hour shift report for the specific date in the summer of 2015, which communicated to staff that they were no longer to disturb resident #010 on night shifts. A review of the resident's care plan, last revised four days prior to the incident in the summer of 2015, provided no information which would direct staff to check on the resident and get them up for the specific ADL during the night.

During an interview with RN #125 on Thursday April 21, 2016, they reported to Inspector #621 that resident #010 had occasions where they exhibited a specific characteristic related to an ADL during the daytime, but was otherwise independent with the specific ADL and did not require staff intervention with this at night. RN #125 also reported that resident #010 spoke with them about their treatment by the PSW, and that the RN made notations in the progress notes and shift report to detail the concerns and wishes of this resident with respect to care related to the specific ADL.

Inspector #621 met with the ADOC #122 who stated that their expectations of staff with

respect to treatment of residents would be that staff treat all residents with dignity and respect, and that care provided was consistent with the resident's individual needs and preferences. The ADOC reviewed resident #010's progress notes from RN #125, a shift report from a specific date in the summer of 2015, and the resident's care plan. The ADOC then indicated that resident #010's rights were not fully respected or promoted, and that staff had not respected the resident's dignity during the incident. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A complaint was received by the Director regarding resident #032's treatment related to a specific diagnosis.

A review of resident #032's health care record by Inspector #625 identified:
- a physician's order dated a specific date in the spring of 2016, that instructed staff to initiate specific interventions related to a potential diagnosis;
- a physician's progress note dated four days after the physician's order, querying a potential diagnosis;
- a physician's progress note dated seven days after the physician's order, indicating that the potential diagnosis was complicating matters;
- a note entered by the DOC eight days after the physician's order, indicating the resident was sent to hospital the previous day and was admitted with a specific diagnosis; and
- a note indicating that the resident had passed away in hospital 12 days after the physician's order.

A review of progress notes from resident #032's attending physician while in acute care included a note dated three days before the resident's death, that indicated the resident was provided with a specific treatment related to the specific diagnosis, and a progress note dated one day before the resident's death, that indicated the resident had the specific diagnosis, the anticipate course of the diagnosis, and the measures that would be taken.

During an interview with Inspector #625 on April 27, 2016, the DOC recounted the timeline with respect to resident #032's specific diagnosis and transfer to hospital including:
- the initial presentation of symptoms on a specific date in the spring of 2016;
- implementation of specific measures related to the diagnosis three days after the

presentation of symptoms;
- specific actions taken five days after the presentation of symptoms;
- the home learning of the specific diagnosis eight days after the presentation of symptoms, when the home contacted the external service provider for specific information related to the diagnosis; and
- notification of the resident's physician of the diagnosis ten days after the initial presentation of symptoms.

The DOC identified that the home had not learned of the information from the external service provider until two days after the information was made available to the home, due to miscommunication with the provider, and that the home intended to, but had not, notified the physician of the information on the date the home learned of the information. The DOC stated that the physician learned of the resident's diagnosis when they attended the home to assess the resident two days after the home had learned of the information. The DOC also stated that they believed the resident's physician did not order treatment for the resident related to the diagnosis while the resident was in the home, as the physician had not been notified of the resident's diagnosis. [s. 3. (1) 4.]

4. A Critical Incident System (CIS) report was submitted to the Director for an incident t that occurred on a specific date in the fall of 2014. The report indicated that resident #019 had difficulty during a meal and began to exhibit symptoms related to the difficulty. The resident's meal ceased and they were moved to a common area by staff for monitoring. Two hours after the difficulty had occurred, a PSW found the resident deceased.

A review of resident #019's health care record by Inspector #625 identified progress notes that corroborated the details in the CIS report but did not indicate any care or monitoring that was conducted from the time of the incident until the resident's death two hours later.

During an interview with Inspector #625 on April 5, 2016, RPN #114 stated that resident #019 was placed in a specific common area after the incident that occurred as there was increased traffic in that room to monitor the resident. RPN #114 stated that, between the time of the incident and the time of resident #019's death, "everyone was walking by and could watch [the resident]" and that there was no policy in place as to the frequency of monitoring of residents. The RPN stated that they did not know at what time, between the incident and the time the resident was found, that the resident expired.

During an interview with Inspector #625 on April 29, 2016, Assistant Director of Care (ADOC) #122 stated that they assessed the resident and provided a report to RPN #114 on the resident's status post-incident. The ADOC indicated that the resident should have been monitored by registered nursing staff between the time of the incident and the time they were found deceased; and that monitoring of the resident during that time should have included an assessment, evaluation of the resident's care plan, a specific type of referral, a possible call to the physician, ongoing monitoring of resident and keeping the resident close to the registered nursing staff. [s. 3. (1) 4.]

5. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to manage his or her own financial affairs, unless the resident lacked the legal capacity to do so.

A complaint was received by the Director regarding resident #016's rights related to finances.

During an interview with Inspector #625, resident #016 and the Inspector discussed the resident's capabilities related to accessing and managing the resident's trust account. Resident #016 stated that they accessed their trust account and explained what they did with respect to the account. The resident discussed the planning they undertook to withdraw specific sums of money, when required.

During interviews with resident #016's substitute decision-maker (SDM) #158, they stated that they had been in contact with the Accounts Receivable Clerk for one of the home's external service providers related to an invoice dated a specific month in 2016, that identified that resident #016 had an outstanding account balance of a specific significant amount. SDM #158 stated that neither they, nor resident #016, had received monthly invoices from the service provide since several years prior, resulting in the balance owed accruing to a significant amount. The SDM further stated that the home had withdrawn a specific amount of money from resident #016's trust account without authorization to apply towards the outstanding balance and, in response to the withdrawal, the SDM instructed the home not to take any money from the resident's account unless the resident signed that they had approved or received it.

Inspector #625 reviewed resident #016's monthly invoices from the external service provider, from the time of their admission to a specific month in 2016, and verified that the statement dated a specific date in the spring of 2016, indicated a significant specific amount was owing, which had accrued beginning years prior.

Inspector #625 reviewed resident #016's trust account statement dated a specific date in the spring of 2016, that included an entry posted on a specific date, for the exact sum that the SDM had indicated was withdrawn by the home and paid to the service provider.

During interviews with Inspector #625, the external service provider's Accounts Receivable Clerk #146 stated that the arrears were identified by service provider's head office in a specific month in the winter of 2015, and that a message was left at the home with respect to the arrears. The Clerk stated that invoices for resident #016 had been mailed to the home in an individual envelope addressed to the resident, which was then placed in a larger envelope addressed to the home's Office Manager. The Clerk stated that invoices were mailed directly to SDM #158 effective a specific month in the spring of 2016.

During interviews with Resident Relations Coordinator (RRC) #115, they stated that they did not dispute that the former Office Manager had received the invoices from the service provider for resident #016.

During a phone interview with the Executive Director (ED) on October 18, 2016, they stated that the home's Resident Relations Coordinator #115 had located a "stack" of invoices from the service provider in the Office Manager's office addressed to resident #016. The ED also stated that, although the invoices had been addressed to resident #016, the home had not forwarded the invoices to the resident for payment, and they had accumulated in the office. [s. 3. (1) 25.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the rights of residents are fully respected and promoted, including 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; as well as the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director related to the administration of an incorrect dose of a narcotic drug to resident #031.

A review by Inspector #625 of a "Medication Incident Report" for an incident that occurred on a specific date in the winter of 2016, identified that resident #031 was administered twice a specific dose of a narcotic medication for several consecutive doses.

A review of the "Narcotic and Controlled Substance Administration Record" identified that a specific amount of the narcotic drug measured in a specific unit had originally been signed for at the time of administration on specific dates, at specific times, in the winter of 2016.

A review of resident #031's health care record included progress notes dated the day of, and the day following, the last medication incident. The progress notes indicated that the resident had required specific interventions by a Registered Nurse, had exhibited specific symptoms related to the medication incidents, and was provided with multiple treatments related to the medication incidents.

A review by Inspector #625 of a "Resident Progress Note" signed by the resident #031's physician, identified that the medication error had occurred and caused specific symptoms and required specific treatment.

During an interview with Inspector #625 on April 21, 2016, Director of Care (DOC) #108 stated that a specific amount and unit of narcotic medication had been ordered and should have been administered by staff but, at the times documented on the "Narcotic and Controlled Substance Administration Record", twice the ordered dose had been administered. [s. 131. (2)]

***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. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**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).**

**Findings/Faits saillants :**

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

A complaint was received by the Director related to resident #016's right to participate in a specific activity.

During an interview with Inspector #625 on April 13, 2016, resident #016 stated that they had participated in the specific activity since they had been admitted to the home several years prior, and had continued to participate in the specific activity until the present day.

A review by Inspector #625 of resident #016's health care record identified progress notes that indicated the resident had engaged in the specific activity beginning from the

time of the resident's admission several years prior.

A review of the home's policy "Smoking - #VII-G-20.10 " last revised January 2015, indicated that the RPN or RN was to update residents' care plans related to participation in a specific activity.

A review by Inspector #625 of resident #016's care plans completed on four specific dates in the winter of 2014 to the fall of 2015, identified that interventions related to the specific activity were not listed in any of the care plans.

During an interview with Inspector #625 on April 13, 2016, ADOC #122 stated that staff had utilized interventions related to the specific activity with resident #016 since their admission several years prior. The ADOC identified several interventions that had been in place.

During interviews with Inspector #625, ADOC #122 and Case Manager #131 stated that the resident's 24 hour care plan for their admission several years prior, as well as care plans completed on six specific dates between the summer of 2013 and the winter of 2015, did not include any data related to the specific activity. Further, they confirmed that care plans completed on three specific dates between the summer of 2014 and the winter of 2015, contained interventions related to an injury that the resident had sustained while engaging in the specific activity, but did not include any interventions related to the resident participating in the specific activity. Both the ADOC and the Case Manager stated that resident #016's care plans did not include the planned care for the resident related to their participation in the specific activity. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A complaint was received by the Director related to bathing practices in the home.

A review of the home's policy "Hygiene, Personal Care & Grooming – VII-G-10.50" last revised January 2015, indicated that, at the time of admission, the PSW would ask the resident about the choice of bathing style and time of day for preferred bathing (i.e. days, evenings or early mornings); tub, shower or sponge bath and report this information to the Charge Nurse. The PSWs would then follow resident specific bathing protocols defined in each resident's care plan.

During an interview with Inspector #625 on April 14, 2016, PSW #139 stated that the Transitions Unit Case Manager #131 created the resident bathing schedule so that each resident received one bath during the day and one bath during the evening.

A review of the current "Transitions Unit Bathing Schedule" by Inspector #625 identified that all 23 residents on the unit were scheduled to have one bath during the day and one bath during the evening per week. A vacant slot was listed that consisted of one day and one evening bath slot per week.

Inspector #625 reviewed:
(a) the "Bath Schedule" which listed resident #036 as having baths on a specific day and a specific evening of the week; and the current care plan for resident #036 which identified that the resident required staff assistance with bath/shower twice weekly and as necessary;
(b) the "Bath Schedule" which listed resident #037 as having baths on a specific day and a specific evening of the week; and the current care plan for resident #037 which identified that the resident required staff assistance with a shower or bath twice weekly and as necessary; and
(c) the "Bath Schedule" which listed resident #038 as having baths on a specific day and a specific evening of the week; and the current care plan for resident #038 which identified that the resident required the assistance of staff with bath/shower twice weekly and as necessary.

During an interview with Inspector #625 on April 14, 2016, Case Manager #131 stated that they spoke to residents on admission to the unit and noted their preferences for day or evening baths, then placed the resident into a day and evening bathing slot. The Case Manager stated that they did not ask residents about their bathing preferences with respect to bed or sponge baths. The Case Manager stated that the plans of care did not identify the preferences of residents #036, #037 and #038, with respect to the preferred type of bath and bathing time for the residents. [s. 6. (2)]

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

A complaint was received by the Director regarding resident #032's treatment related to a specific diagnosis.

During an interview with Inspector #625 on April 27, 2016, an employee from an external service provider confirmed that testing for a specific diagnosis for resident #032 was completed on a specific date in the spring of 2016, and that the results were phoned to the home the same day.

Inspector #625 reviewed a "RN Report Sheet" dated two days after the testing was completed by the external service provider, for the day shift, that included an entry that identified resident #032 as having a specific diagnosis, that DOC #108 called the external service provider for information, and that the RN was to call the physician for an order. The evening shift report listed resident #032 as having a specific diagnosis but did not have the entry indicating this checked off, as the other items listed were.

During an interview with Inspector #625 on April 28, 2016, RN #125 stated that they had phoned the physician four days after the testing was completed by the external service provider, regarding resident #022's general health, and informed the physician of the resident's diagnosis that evening, when the physician attended the home.

A review of resident #032’s health care record identified a note entered by the physician four days after the testing had been completed by the external service provider, indicating that the diagnosis was complicating matters.

During interviews with Inspector #625 on April 27 and 28, 2016, DOC #018 stated that the home had learned of the diagnosis on the day shift two days after the external service provider had completed the testing, when the home contacted the provider to inquire about the results. The DOC stated that the RN working the evening shift on the date the home learned of the diagnosis, had not contacted the physician as was expected.

During these interviews, the DOC identified that the home had not learned of the diagnosis on the day that the external service provider had completed the testing, but had had learned of the diagnosis two days later, due to miscommunication with the provider. The DOC also stated that the home had intended to notify the physician of the result when they learned of it two days after the testing was completed, but did not notify the physician of the result until the physician attended the home to assess the resident four days after the testing was completed. [s. 6. (4) (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 there is a written plan of care for each resident that sets out the planned care for the resident; and that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, where the Act or 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, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10, s. 114 (2) requires the licensee to 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.

A complaint was received by the Director related to the administration of an incorrect

dose of a narcotic drug to resident #031.

A review by Inspector #625 of MediSystem "Narcotic and Controlled Drug Administration Record – Example" identified that entries for wasted doses were to be filled in completely with an explanation and a signature of a witness. Columns to be completed included the date, time, dose/amount given and amount wasted.

A review of MediSystem "Narcotic and Controlled Substance Administration Record" for resident #031 contained an entry dated a specific date in the winter of 2016, which was not complete and did not list the time of disposal, did not list the quantity administered and/or disposed of that totaled a complete dose amount, and did not provide an explanation as to why the medication was disposed of.

During interviews with Inspector #625, DOC #108 stated that the entry dated a specific day in the winter of 2016, which did not have a time listed, was not entered correctly and did not reflect the amount of narcotic administered and the amount wasted. [s. 8. (1) (b)]

2. Ontario Regulation 79/10, s. 49 (1) requires the licensee to have a falls prevention and management program that must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A CIS report, submitted to the Director for a fall experienced by resident #020 on a specific date in the winter of 2015, identified that the resident had two falls in a specific month of 2015, ten falls in a specific month of 2015, five falls in a specific month of 2015 and three falls (to the date of the CIS report) in a specific month of 2015.

A review by Inspector #625 of the home's policy titled "Falls Prevention – VII-G-30.00" last revised January 2015, identified that the registered staff were to complete the "Falls Risk Assessment" in the electronic documentation system within 24 hours of admission or re-admission, as triggered by the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Resident Assessment Protocol (RAP), and when a significant change in status (a physiological, functional or cognitive change in status) occurred.

On April 7, 2016 Inspector #625 reviewed resident #020's "Post Fall Huddles" from a specific date in the summer of 2015 to present, and identified that the resident had "Post Fall Huddles" completed after falls three times in a specific month of 2015, ten times in a

specific month of 2015, five times in a specific month of 2015, six times in a specific month of 2015, three times in a specific month of 2016, once in a specific month of 2016, and twice in a specific month of 2016.

During an interview with Inspector #625 on April 8, 2016, RPN #116 identified, through a review of the resident's health care record, that resident #020 started using an assistive mobility device in a specific month of 2015.

During an interview with Inspector #625 on April 11, 2016, ADOC #122 stated that, for resident #020, a "Falls Risk Assessment" should have been completed as triggered by the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), specifically if a Resident Assessment Protocol (RAP) was triggered for falls due to a fall within 30 or 180 days, and when the resident experienced a significant change in status such as when the resident began using the assistive mobility device. The ADOC identified that "Falls Risk Assessments" should have been completed, as triggered by the resident's falls through RAI-MDS, on three specific dates from the fall of 2015 to the spring of 2016. The ADOC also identified that the resident's use of the assistive mobility device qualified as a significant change and a "Falls Risk Assessment" should have been completed at that time. The ADOC acknowledged that staff did not complete the required "Falls Risk Assessments" as triggered by RAI-MDS, or the significant change in the resident's status. [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 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 is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A complaint was received by the Director related to the safety of bed systems in the home.

A review of the home's policy titled "Bed Entrapment – VII-E-10.30", last revised July 2015, identified that bed entrapment testing would be conducted initially on each resident's bed system and annually thereafter, to prevent risk of entrapment.

During an interview with Inspectors #621 and #625, the Environmental Services Supervisor (ESS) #109 identified that the home's maintenance staff conducted bed system evaluations. The home provided Inspector #621 with copies of the bed system evaluations completed by the home for 2013, 2015 and 2016. However, the home was not able to provide a bed system evaluation report for 2014.

During an interview with Inspectors #621 and #625, the Executive Director (ED) reported that it was the licensee's expectation that the home completed bed entrapment testing on resident bed systems on admission, annually, and when there was a change made to a bed, or a change in resident condition that increased their risk for entrapment. It was identified by the ED that no bed system audit could be produced by the home for 2014 to demonstrate annual bed entrapment testing had been completed, and the ED could not confirm that the testing had been completed on any or all beds. [s. 15. (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, where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A complaint was received by the Director related to the safety of bed systems in the home.

On April 5, 2016, Inspector #621 and #625 observed five bed systems with mattresses that did not properly fit the bed frames.

On April 6, 2016, during an interview with Inspectors #621 and #625, Maintenance employee #106 identified the bed system in room 117 had a mattress shorter than the bed frame and had loose mattress keepers. The mattress shifted on the frame creating gaps between the mattress and both the head and foot boards of the bed. In room 105, Maintenance employee #106 identified that the mattress keepers were in a position that did not keep the mattress in place.

On April 6, 2016, during an interview with Inspectors #621 and #625, Maintenance employee #110 identified a loose headboard in room 320, that the mattress was too short for the bed and that the mattress keepers were not keeping the mattress in a fixed position, resulting in large gaps at the head or foot of bed. The employee stated that the mattress was too short for the bed frame.

On April 7, 2016, during an interview with Inspectors #621 and #625, Maintenance employee #111 attended room 323 with the Inspectors and identified that there were large gaps between the mattress and the head board and foot board, that the mattress keepers failed to keep the mattress in place, and that the 76 inch mattress did not fit on the bed frame.

During an interview with Inspectors #621 and #625 on April 6, 2016, the Executive Director (ED) acknowledged that the home had identified bed systems that had required the adjustment of head and foot boards, adjustment of mattress keeper placement on the mattress decks, installation of mattress keepers on the mattress decks and replacement of shorter mattresses with longer ones. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #7: 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).**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

A complaint was received by the Director related to an incident of abuse that was witnessed by the Resident Relations Coordinator (RRC) #115 and a PSW on a specific

date in the summer of 2015, where resident #021 was found in a co-resident's room and the co-resident was touching resident #021 under their clothing.

During an interview with RCC #115 on April 14, 2016, it was confirmed that they witnessed an incident which was perceived as sexual in natural between resident #021 and resident #028 on a specific date in the summer of 2015. The RCC #115 reported that they separated the residents, told staff that under no circumstances residents were to be alone together, recorded the incident in the resident's progress notes, notified the substitute decision-makers for both residents, and spoke the Directors of Care, Assistant Directors of Care and the Executive Director at a management team meeting the next day.

During an interview with the Executive Director on April 28, 2016, it was confirmed to Inspector #621 that the incident witnessed by the RCC #115 was not investigated. [s. 23. (1) (a)]

2. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Two letters of complaint were received by the Director related to alleged negligence and abuse that occurred on a specific date in the summer of 2015, to resident #002.

Inspector #625 reviewed a CIS report submitted to the Director for an incident that occurred on the specific date in the summer of 2015. The report identified that, on the specific date, resident #002's family member witnessed a staff member allegedly abuse resident #002 by performing a specific action, that the family member demonstrated the action on PSW #101, that the resident was checked for signs of the alleged abuse, and that the Charge Nurse notified the manager on call of the incident.

Inspector #625 reviewed a letter of complaint written by resident #002's family member #159 and received by the home 11 days after the incident that occurred in the summer of 2015. The letter alleged that, on the specific date in the summer of 2015, and on several other occasions, negligence and abuse had occurred.

Inspector #625 reviewed a second complaint letter written by family member #159, dated 28 after the date of the specific incident that occurred in the summer of 2015 and received by the home the day after the date on the letter. The letter alleged that physical abuse had occurred and detailed the incident that occurred on the specific date in the

summer of 2015, identified in the CIS report submitted by the home.

During an interview with Inspector #625 on April 7, 2016, family member #159 stated that they witnessed resident #002 abused when a staff member performed a specific action to the resident.

During an interview with Inspector #625 on April 11, 2016, the Executive Director stated that the home investigated the allegation made by resident's #002's family member and interviewed staff, took statements and assessed resident #002 for possible injury, but that the home did not report to the Director the results of the investigation conducted by the home into the allegation of staff to resident physical abuse that occurred on the specific date in the summer of 2015. [s. 23. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.***

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**WN #8: 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 that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Director, related to an incident of abuse that was witnessed by the Resident Relations Coordinator (RRC) #115 and a PSW on a specific date in the summer of 2015, where resident #021 was found in a co-resident's room and the co-resident was touching resident #021 under their clothing.

The home's policy "Prevention of Abuse & Neglect of a Resident – VII-G-10.00", last revised January 2015, indicated that all employees were required to immediately report any suspected or known incidents of abuse or neglect to the Director of MOHLTC. The policy also stated that the Charge Nurse would provide support to the staff member in immediately reporting any of the following to the Director (MOHLTC), if outside of normal business hours, the ACTION line would be called.

A review of Critical Incident System reports submitted by the home identified that a report related to the incident had not been submitted to the Director.

During an interview with Inspector #621 on April 14, 2016, Resident Relations Coordinator (RRC) #115 confirmed that they witnessed an incident which was perceived as sexual in nature between resident #021 and resident #028 on a specific date in the summer of 2015. The RRC #115 reported that they separated the residents, told staff that under no circumstances residents were to be alone together, recorded the incident in the resident's progress notes, notified the substitute decision-makers for both residents, and spoke to the Directors of Care, Assistant Directors of Care and the Executive Director at a management team meeting the following day.

During an interview with the Executive Director on April 28, 2016, it was confirmed to Inspector #621 that the incident as witnessed by the RRC #115 was not reported to the Director. [s. 24. (1)]

2. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident physical abuse involving residents #011 and #013, that the report indicated occurred on ten days prior.

Resident #013's health care record was reviewed by Inspector #625. Two progress notes, dated three days prior to the date the CIS report was submitted, corroborated the details in the CIS report, and identified that resident #013 pointed at resident #011, identified resident #011 specifically by name, and stated what specifically resident #011 had done to resident #013 that resulted in an injury to resident #013.

During an interview with Inspector #625 on April 21, 2016, Case Manager #131 confirmed that the date of the incident should have been listed as three days before the date the CIS report was submitted, not ten days before. The Case Manager stated that the date of the incident was a Sunday and the Charge Nurse on duty at the time should have notified the Director. The Case Manager stated that, during the home's management conference on the Monday following the incident, the home determined that a CIS report should be submitted, and that the first notification to the Director occurred via the CIS report, submitted 74 hours after the incident of physical abuse occurred, but that the Director should have been notified immediately. [s. 24. (1) 2.]

3. A CIS report was submitted to the Director on a specific date in the summer of 2014, for an incident of resident to resident physical abuse involving resident #011.

During a review of resident #011's health care record by Inspector #625, a progress note dated a specific date in the summer of 2015 was reviewed, that indicated PSW #151

witnessed residents #011 and #042 as the PSW walked into a bathroom. The note identified that the residents appeared to be engaged in a specific activity, that the PSW called RPN #157 for assistance at 1945 hours, and that the RPN informed RN #143 of the incident.

During an interview with Inspector #625 on April 28, 2016, RN #143 stated that the RN's role as Charge Nurse was to provide support to staff members in immediately reporting abuse immediately to the Director.

During an interview with Inspector #625 on April 28, 2016, the DOC #108 stated that the incident should have been reported to the Director by RN #143, the Charge Nurse at the time of the incident. [s. 24. (1) 2.]

4. Inspector #621 reviewed a CIS report submitted to the Director on a specific date in the winter of 2015, which alleged that the previous day, PSW #103 abused resident #008, as well as neglected to include the resident in specific decision-making activities and neglected to respond to the resident when spoken to by the resident.

A report was made to ADOC #122, DOC #108 and DOC #128 at 1235 hours the day before the CIS report was submitted by an external consultant, who had been in the home and witnessed the incidents. The home did not submit a Critical Incident System (CIS) report to the Director until 1510 hours the day after they learned of the incidents.

Inspector #621 reviewed the CIS report with ADOC #122 and DOC #128 who stated that it was their expectation that any incident of alleged, suspected or actual abuse or neglect be immediately reported to the Director. Both ADOC #022 and DOC #128 confirmed that the incident was not immediately reported. [s. 24. (1) 2.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that 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: 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, to be implemented voluntarily.***

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**WN #9: 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 no staff performed their responsibilities before

receiving training in all Acts, regulations, policies of the Ministry, and similar documents, including policies of the licensee, that were relevant to the person's responsibilities.

A complaint was received by the Director related the safety of bed systems in the home.

Ontario Regulation 79/10 section 15 (1) (a) indicates that every licensee of a long-term care home shall ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During an interview with Inspector #621 and #625, Environmental Services Supervisor (ESS) #109 reported that that the home's maintenance staff completed bed system evaluations. The ESS indicated that they and Maintenance employee #106 were trained by the manufacturer on the use of the bed system measurement device. They stated that the three other maintenance staff had not receive training from the manufacturer but were required to review the user manual to learn how to conduct bed system evaluations.

On April 6, 2016, Maintenance employee #111 reported that they had not received formal training from the manufacturer of the bed system measurement device, but had read the manual. When completing bed system evaluations in rooms 323 and 314, the maintenance employee was not clear on the proper use of the bed system measurement device.

A review of the maintenance work order reports between a specific date in the summer of 2015 and a specific date in the spring of 2016, identified a total of 35 bed system evaluations were completed by Maintenance employees #110, #111 and #155. The three Maintenance employees had completed a total 28 repairs to resident beds, including seven work orders requesting evaluations be done on bed systems. The one maintenance employee who had been formally trained on how to use the bed system measurement device did not complete any of the seven bed system evaluations using the device.

During an interview with Inspector #621 and #625, the Executive Director (ED) said they observed Maintenance employee #111 attempt to conduct a bed system audit and reported to Inspectors #621 and #625 that the staff person was unable to complete a bed audit using the bed system measurement device and that training was required.

On April 7, 2016, the ED reported that bed system auditing would be reassigned to the home's managers, once training on the proper use of the bed system measurement device was completed with the manufacturer. [s. 76. (2) 10.]

***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 no person mentioned in subsection (1) performs their responsibilities before receiving training in all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During tours of the home by Inspector #625, hazardous substances were observed to be accessible to residents.

On April 5, 2016, Inspector #625 observed an unattended, unlocked housekeeping cart in the hallway outside of an entrance to a resident home area. The cart contained Chemsyn Venus Pro-Creme Liquid Cleaner and Chemsyn Glass Cleaner, both of which were labeled with a Workplace Hazardous Materials Information System (WHMIS) Poisonous and Infectious Material label. After two to three minutes, Housekeeper #134 approached the cart and stated, in reply to the Inspector's questions, that the cart should not have been left unattended when chemicals were accessible to residents and that the chemicals should be locked when not in use or unsupervised.

On April 7, 2016, Inspector #625 observed an unattended housekeeping cart in the hallway outside of a specific room. The cart held Chemsyn Venus Pro-Creme Liquid Cleaner on an unlocked shelf. Inspector #625 waited at the unattended cart for three to four minutes and then found Housekeeper #135 in a resident's bathroom. Housekeeper #135 stated that the unlocked and unsupervised chemical on the cart shelf was usually kept in that location, accessible to residents.

On April 14, 2016, Inspector #625 observed an unattended housekeeping cart in the hallway on a resident home area. The cart held Chemsyn Jupiter 8 Extreme Eraser which was labeled with a WHMIS Poisonous and Infectious Material label. Various additional cleaning solutions were in the unlocked cart cupboard. After four minutes Housekeeper #136 returned to the cart. Housekeeper #136 stated that the cart cupboard should be locked when staff went on breaks and the chemicals should be kept in the locked cupboard.

During an interview with Inspector #625 on April 29, 2016, Environmental employee #137 stated that housekeeping carts should be locked, with chemicals locked in the cart cupboard when unattended.

During an interview with Inspector #625 on April 5, 2016, the Executive Director stated that chemicals on the Housekeeping carts were to be locked when not in use.

During an interview with Inspector #625 on April 29, 2016, Environmental Services Supervisor (ESS) #109 attended a Housekeeping closet on a resident care area with the Inspector and discussed the chemicals stored on the Housekeeping carts. The following chemicals were identified on the cart as having WHMIS Poisonous and Infectious Material labels: Chemsyn Venus Pro-Creme Liquid Cleaner; Chemsyn Earth Tone Odour Conteractant Neurtralizer; and Chemsyn Jupiter 8 Extreme Cleaner. The ESS stated that Housekeeping carts should be locked and secured when not in use and, when in use by staff, the cart must be in the sight of staff to ensure resident safety. [s. 91.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts**

**Specifically failed to comply with the following:**

**s. 241. (7) The licensee shall,**
**(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).**

**s. 241. (12) A licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, shall not receive, hold or administer the property of a resident in trust other than as provided for in this section. O. Reg. 79/10, s. 241 (12).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that quarterly itemized written statements, respecting money held by the licensee in trust for the resident, that included deposits, withdrawals and the balance of the resident's funds as of the date of the statement, were provided to the resident, or to a person acting on behalf of a resident.

A complaint was received by the Director regarding the home's management of resident #016's finances.

During an interview with Inspector #625 on April 15, 2016, resident #016 stated that their substitute decision-maker (SDM) #158 had received one trust account statement for the resident since their admission to the home several years prior.

During an interview with Inspector #625 on April 15, 2016, SDM #158 stated that they had not received quarterly trust account statements from the home and had only recently received two statements to date, both in 2016. The SDM stated that they had received several trust account statements from the home over several years, when they called the home and requested them.

A review by Inspector #625 of resident #016's trust account statements provided by Office Manager #145, identified trust account statements, between two specific dates from the fall several years earlier to the winter of 2016, dated from seven to 185 days apart.

During an interview with Inspector #625 on April 15, 2016, the Office Manager #145 stated that the trust account statements generated by the previous Office Manager had not been done quarterly and were not mailed to families until 2016. The Office Manager stated, regarding a trust account statement dated a specific date in 2014 for resident #016, that the statement indicated it was generated to cover the period of time of 179 days.

During an interview with Inspector #625 on April 15, 2016, Resident Relations Coordinator (RRC) #115 stated that resident trust account statements had not been sent out to residents or substitute decision-makers until 2016. When specifically asked about resident #016's trust account statements, the RRC confirmed that, although the resident had resided in the home for several years, trust account statements had only been provided since 2016. [s. 241. (7) (f)]

2. A complaint was received by the Director regarding alleged missing money from the trust account of resident #012.

During an interview with Inspector #621, a family member of resident #012 reported that a significant sum of money may have been missing from resident #012's trust account, which should have been transferred when the resident moved to the home. The family member reported that the resident was not provided statements on the trust account from the home since the resident's admission.

During an interview with resident #012, it was verified that, since they had been admitted to the home, only two trust account statements had been provided to the resident from the home.

On review of these statements by Inspector #621, it was identified that both statements were for 2016. The statements listed transactions from periods of time in 2016.

During an interview on April 14, 2016, the Resident Relations Coordinator #115 and Office Manager #145 indicated that the home had started providing written trust account statements to residents in 2016, and had not provided quarterly statements prior to 2016. [s. 241. (7) (f)]

3. The licensee, including a municipality, municipalities or a board of management referred to in section 133 of the Act, has failed to ensure that they did not receive, hold or administer the property of a resident in trust other than as provided for in this section.

A complaint was received by the Director regarding the home's involvement in resident #016's finances.

During an interview with Inspector #625, resident #016's substitute decision-maker (SDM) #158 stated that the home had withdrawn a specific sum of money from resident #016's trust account, without authorization, to apply towards an invoice from an external service provider. In response to the withdrawal, the SDM stated they had instructed the home not to take any money from the resident's account unless the resident signed that they had approved or received it.

Inspector #625 reviewed resident #016's trust account statement dated a specific date in the spring of 2016, including an entry posted on a specific date, for a payment in the amount specified by the SDM, made to the external service provider.

During interviews with Inspector #625, the external service provider's Accounts Receivable Clerk #146 confirmed that provider had received a payment of a specific amount made by the home from resident #016's trust account.

During interviews with Resident Relations Coordinator (RRC) #115, they acknowledged that they had made the payment of the specific amount from resident #016's trust account to the external service provider, without the consent of resident #016 or SDM #158, and without authorization to pay the provider's invoices from resident #016's trust account.

In response to Inspector #625's request for the home to provide a policy or procedure on

the payment of pharmacy or other third party invoices or bills, RRC #115 faxed the Inspector a handwritten document regarding the payment of the external service provider's invoices on the home's letterhead written by the home's Office Manager #145. The document identified that payment through a resident trust account could be set up by a resident's SDM.

During interviews with Inspector #625 on October 17 and 21, 2016, Executive Director #107 stated that the home paid invoices from the external service provider for one SDM on behalf of one resident, and for approximately five residents who receive income from the Ontario Disability Support Program, from resident trust accounts. In addition, the ED acknowledged that the home had made a payment of a specific sum of money from resident #016's trust account to the external service provider. [s. 241. (12)]

***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 quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement is provide to the resident, or to a person acting on behalf of a resident, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident, or the operation of the home, to the Director.

The Director received two letters of complaint regarding care provided to resident #002.

Inspector #625 reviewed a letter of complaint written by resident #002's family member #159 and received by the Director on a specific date in the summer of 2015. The letter indicated that there were numerous unresolved care issues and referenced an attached, undated letter addressed to the home that alleged that, on a specific date in the summer of 2015, and on several other occasions, negligence and abuse had occurred. The letter further alleged negligent treatment of resident #002 and detrimental practices to the well-being of residents.

Inspector #625 reviewed a second letter dated a specific date in the summer of 2015, and faxed to the Director by the home on a specific date in the summer of 2015. This letter was written by family member #159 and alleged that physical abuse had occurred and that improper care had been provided to resident #002 related to several care areas.

Inspector #625 reviewed an undated letter from the home, signed by the home's Executive Director, to resident #002's family member. The letter acknowledged receipt of a letter submitted by the family member and received by the home on a specific date in the summer of 2015, outlining in more detail the care issues the family member originally expressed in their letter received by the home on a specific date in the summer of 2015.

During an interview with Inspector #625 on April 28, 2016, the Executive Director (ED) stated that the letter of complaint alleging negligence and abuse, negligent treatment of resident #002 and detrimental practices to the well-being of residents was received by the home on a specific date in the summer of 2015. The ED stated the home received the second letter of complaint alleging that physical abuse had occurred and that improper care had been provided to resident #002 related to several care areas on a specific date in the summer of 2015. The ED confirmed faxing the second complaint letter, received by the home on a specific date in the summer of 2015, to the Director three days after the letter had been received by the home. The ED stated that they had not forwarded the first complaint letter received by the home to the Director. [s. 22. (1)]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquisition, in the case of new items.

A complaint was received by the Director related to unlabelled personal items in a shared washroom.

On April 27, 2016, Inspector #625 observed unlabelled personal items, that appeared to have been used, including a comb in a specific room's shared washroom; two toothbrushes and a comb in a specific room's washroom; a hair brush, a toothbrush holder, a toothbrush and a denture cup in a specific room's washroom; two toothbrushes and a hairbrush in a specific room's washroom.

During an interview with Inspector #625 on April 27, 2016, PSW #138 accompanied the Inspector to the washrooms for the four specific rooms and stated that they could not identify to whom each personal item belonged to as none were labelled. The PSW stated that the expectation was that all resident personal items were labelled.

During an interview with Inspector #625 on April 27, 2016, ADOC #122 stated that all resident personal items including toothbrushes, combs and denture cups should be labelled. [s. 37. (1) (a)]

**WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home**

**Specifically failed to comply with the following:**

**s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,**
**(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).**
**(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).**
**(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the applicant's admission to the home was approved, unless the home lacked the physical facilities necessary to meet the applicant's care requirements, the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements, or circumstances existed which were provided for in the regulations as being a ground for withholding approval.

A complaint was submitted to the Director indicating that the home denied admission of an applicant due to specific criteria identified by the home.

A review of the home's refusal letters dated two specific dates in 2015, identified that the licensee had declined the applicant's admission for specific reasons which the home listed.

On April 12, 2016, Inspector #621 interviewed Resident Relations Coordinator #115 and the Executive Director (ED), who verified that the home had refused the applicant's admission based on the specific reasons listed by the home in the letter. The ED confirmed that the home did not refer to the legislation to guide their decision and did not refuse to admit this applicant due to a lack of physical facilities, or lack of staff or nursing expertise. [s. 44. (7)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response.

Two letters of complaint were received by the Director related to resident #002.

Inspector #625 reviewed the two letters of complaint written by resident #002's family member #159 and received by the home on two specific dates in the summer of 2015.

Inspector #625 reviewed a response letter signed by the Executive Director (ED) to family member #159, mailed to the complainant on a specific date in the summer of 2015. The letter read that the home had received a copy of the letter submitted on the second specific date, outlining care issues originally expressed in the letter received on the first specific date. The ED requested the opportunity to investigate the incidents and, once the investigation was completed, would contact family member #159 to set up a meeting to discuss the results.

Inspector #625 reviewed an email dated a specific date in the summer of 2015, sent from the Vice President of Operations to family member #159. The email indicated that the Vice President had phoned and left a message for the complainant to return the call to further discuss the concerns.

During an interview with Inspector #625 on April 11, 2016, the ED stated that the home had attempted to contact the complainant to respond to the complaint letters by mail, email and phone. They stated that the home had phoned the complainant "a couple of times" and that the Resident Relations Coordinator #115 would have those dates.

During an interview with Inspector #625, Resident Relations Coordinator #115 was not able to provide the dates or description of the responses to the complainant made by phone, and stated that they were not documented. [s. 101. (2)]

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that, when in receipt of a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act, a copy of the complaint was submitted to the Director.

Two letters of complaint were received by the Director regarding resident #002. The first letter, received on a specific date in the summer of 2015, was undated, and indicated that, on the evening of a specific date in the summer of 2015, and on several other occasions, negligence and abuse had occurred.

The home's policy "Complaints – Response Guidelines – VI-G-10.00" last revised January 2015, indicated that the Executive Director would inform the MOHLTC of the complaint as per Ministry regulation; and at the conclusion of the investigation, the home was to notify the MOHLTC Centralized Intake, Assessment and Triage Team (CIATT) and send the original complaint letter.

Inspector #625 reviewed the home's complaint investigation file for written letters of complaint from resident #002's family member and received by the home on two specific dates in the summer of 2015. The file did not contain any record to indicate that a copy of the first complaint letter was sent to the Director by the home.

During an interview with Inspector #625 on April 11, 2016, the ED stated that they had not forwarded the first complaint letter received by the home to the Director. [s. 103. (1)]

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**WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident, followed by the required report under subsection (4) including an environmental hazard that affected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including, a breakdown of a major system in the home.

A complaint was submitted to the Director in the summer of 2015, which indicated that the home had a sewage back up.

During an interview with Inspector #621 on April 13, 2016, the Executive Director (ED) identified that there had been an issue with a leak in the main sewage drainage pipe in the crawl space underneath the Transitions Unit. The ED stated that this concern was first identified on a specific date in the summer of 2015, when the home's fire panel was flashing that there was an issue in the basement under one of the resident home areas. An assessment of the area identified a leak in the crawl space and a puddle of stagnant water present. The ED also stated that a follow up inspection by Environmental Services Supervisor #109 verified a visible crack in a 12 inch drain pipe connecting into the town's drainage system.

The ED reported to Inspector #621 that contractors were brought into complete the drainage system repairs which occurred on two specific dates, 13 days apart, in the fall of 2015. A contingency plan was implemented on those days, to accommodate residents from the resident care area and their care needs while repairs were completed. This included taking residents off unit for both days on outings in the community, and/or accommodating the residents on other units that were not effected, for a cumulative period of more than 6 hours.

A review of the homes policy entitled "MOHLTC – Critical Incident Reporting – XXIII-C-10.90" last revised January 2015, indicated that the Executive Director (ED) or designate would ensure that the Ministry of Health and Long Term Care Critical Incident System report was initiated, and follow through for all incidents that met the criteria. The procedures section identified that the ED would ensure that all reports were filed within the necessary guidelines.

During an interview with the ED on April 14, 2016, it was confirmed that this incident involved a breakdown of a major system in the home and constituted a critical incident, and that it had not been reported to the Director. [s. 107. (3) 2. ii.]

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 sous la Loi de 2007 sur les foyers de soins de longue durée**

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**Issued on this 24th day of October, 2016**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére 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) :** | KATHERINE BARCA (625), JULIE KUORIKOSKI (621), SHEILA CLARK (617) |
| **Inspection No. / No de l'inspection :** | 2016_433625_0004 |
| **Log No. / Registre no:** | 008869-14, 001605-15, 004521-15, 008247-15, 016479-15, 017103-15, 017279-15, 021991-15, 026144-15, 026390-15, 028606-15, 032064-15, 004434-16, 010671-16, 011384-16 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Oct 21, 2016 |
| **Licensee / Titulaire de permis :** | 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP<br>302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Muskoka Shores Care Community<br>200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3 |
| | Angela Coutts |

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

**Ministére 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

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

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To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee shall:
a) ensure that the rights of residents are fully respected and promoted including the right to be properly cared for in a manner consistent with his or her needs.

b) develop and implement procedures for the monitoring of residents in the home. The procedures shall identify the role of each discipline in the monitoring of residents, including residents whose health status clinically indicates that enhanced monitoring is required.

c) develop and implement written procedures for communication that support timely, accurate and complete communication of pertinent health information with specific external service providers servicing the home, physicians and other health care professionals providing care to the residents in the home, and within the home's internal nursing staff.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A Critical Incident System (CIS) report was submitted to the Director for an incident that occurred on a specific date in the fall of 2014. The report indicated that resident #019 had difficulty during a meal and began to exhibit symptoms related to the difficulty. The resident's meal ceased and they were moved to a

common area by staff for monitoring. Two hours after the difficulty had occurred, a PSW found the resident deceased.

A review of resident #019's health care record by Inspector #625 identified progress notes that corroborated the details in the CIS report but did not indicate any care or monitoring that was conducted from the time of the incident until the resident's death two hours later.

During an interview with Inspector #625 on April 5, 2016, RPN #114 stated that resident #019 was placed in a specific common area after the incident that occurred as there was increased traffic in that room to monitor the resident. RPN #114 stated that, between the time of the incident and the time of resident #019's death, "everyone was walking by and could watch [the resident]" and that there was no policy in place as to the frequency of monitoring of residents. The RPN stated that they did not know at what time, between the incident and the time the resident was found, that the resident expired.

During an interview with Inspector #625 on April 29, 2016, Assistant Director of Care (ADOC) #122 stated that they assessed the resident and provided a report to RPN #114 on the resident's status post-incident. The ADOC indicated that the resident should have been monitored by registered nursing staff between the time of the incident and the time they were found deceased; and that monitoring of the resident during that time should have included an assessment, evaluation of the resident's care plan, a specific type of referral, a possible call to the physician, ongoing monitoring of resident and keeping the resident close to the registered nursing staff. (625)

2. A complaint was received by the Director regarding resident #032's treatment related to a specific diagnosis.

A review of resident #032's health care record by Inspector #625 identified:
- a physician's order dated a specific date in the spring of 2016, that instructed staff to initiate specific interventions related to a potential diagnosis;
- a physician's progress note dated four days after the physician's order, querying a potential diagnosis;
- a physician's progress note dated seven days after the physician's order, indicating that the potential diagnosis was complicating matters;
- a note entered by the DOC eight days after the physician's order, indicating the resident was sent to hospital the previous day and was admitted with a specific

diagnosis; and
- a note indicating that the resident had passed away in hospital 12 days after the physician's order.

A review of progress notes from resident #032's attending physician while in acute care included a note dated three days before the resident's death, that indicated the resident was provided with a specific treatment related to the specific diagnosis, and a progress note dated one day before the resident's death, that indicated the resident had the specific diagnosis, the anticipate course of the diagnosis, and the measures that would be taken.

During an interview with Inspector #625 on April 27, 2016, the DOC recounted the timeline with respect to resident #032's specific diagnosis and transfer to hospital including:
- the initial presentation of symptoms on a specific date in the spring of 2016;
- implementation of specific measures related to the diagnosis three days after the presentation of symptoms;
- specific actions taken five days after the presentation of symptoms;
- the home learning of the specific diagnosis eight days after the presentation of symptoms, when the home contacted the external service provider for specific information related to the diagnosis; and
- notification of the resident's physician of the diagnosis ten days after the initial presentation of symptoms.

The DOC identified that the home had not learned of the information from the external service provider until two days after the information was made available to the home, due to miscommunication with the provider, and that the home intended to, but had not, notified the physician of the information on the date the home learned of the information. The DOC stated that the physician learned of the resident's diagnosis when they attended the home to assess the resident two days after the home had learned of the information. The DOC also stated that they believed the resident's physician did not order treatment for the resident related to the diagnosis while the resident was in the home, as the physician had not been notified of the resident's diagnosis.

The decision to issue this compliance order was based on the scope being isolated to two residents and, although the home did not have a compliance history in this area of legislation, the severity indicated actual harm occurred. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2016

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

**Order / Ordre :**

The licensee shall:

a) ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber;

b) review dosage calculations for specific types of drugs with the registered nursing staff involved in resident #031's medication incidents; and

c) provide training on accurate and complete documentation of the home's "Narcotic and Controlled Substance Administration Record" to the registered nursing staff involved in resident #031's medication incidents.

**Grounds / Motifs :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director related to the administration of an incorrect dose of a narcotic drug to resident #031.

A review by Inspector #625 of a "Medication Incident Report" for an incident that occurred on a specific date in the winter of 2016, identified that resident #031 was administered twice a specific dose of a narcotic medication for several consecutive doses.

A review of the "Narcotic and Controlled Substance Administration Record" identified that a specific amount of the narcotic drug measured in a specific unit had originally been signed for at the time of administration on specific dates, at

specific times, in the winter of 2016.

A review of resident #031's health care record included progress notes dated the day of, and the day following, the last medication incident. The progress notes indicated that the resident had required specific interventions by a Registered Nurse, had exhibited specific symptoms related to the medication incidents, and was provided with multiple treatments related to the medication incidents.

A review by Inspector #625 of a "Resident Progress Note" signed by the resident #031's physician, identified that the medication error had occurred and caused specific symptoms and required specific treatment.

During an interview with Inspector #625 on April 21, 2016, Director of Care (DOC) #108 stated that a specific amount and unit of narcotic medication had been ordered and should have been administered by staff but, at the times documented on the "Narcotic and Controlled Substance Administration Record", twice the ordered dose had been administered.

The decision to issue a compliance order was based on the severity which resulted in actual harm occurring. The scope was isolated to one resident and the home has a compliance history in this area including a Voluntary Plan of Correction issued during inspection #2013_109153_0012 conducted on May 13, 2013. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

**Issued on this 21st day of October, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Katherine Barca

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office