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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2016	2016_440210_0013	023960-16	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

St. George Care Community
225 ST. GEORGE STREET TORONTO ON M5R 2M2

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

SLAVICA VUCKO (210), DEREGE GEDA (645), NITAL SHETH (500), SIMAR KAUR (654), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, and September 1, 2016.

With this RQI the following Critical Incident (CI) inspections: prevention of abuse and neglect 018787-16, 018435-16; duty to protect 004228-14, 007745-14, 030534-15, 030534-15; falls prevention 025331-16; transfer and positioning 026133-16; reporting and complaints 026128-16; and complaints: residents' bill of rights 019421-16, 013153-16, 016491-16; personal care and services 024367-16; pest control 009571-16; infection prevention and control 009571-16; emergency plans 003688-15; were inspected.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), acting Director of Care (DOC), Nurse Managers (NM), Director of Environmental Services (DEVS), Director of Dietary Services, Director of Programs, Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), physiotherapist (PT), personal support workers (PSW), resident relation coordinator, dietary aides (DA), activity aides (AA), staffing clerk, housekeeping staff, receptionist, Residents' Council President, Family Council representative, residents and family members.

During the course of the inspection, the inspectors conducted a tour of the resident home areas, observed medication administration, dining services, resident and staff interactions, reviewed clinical health records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.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).

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

Findings/Faits saillants :

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

Observation on two identified dates revealed that resident #004's bed had one identified partial rail in the up position. A review of the current MDS assessment, revealed that the resident uses bed rails for bed mobility and transfer. A review of the resident's written care plan revealed that the resident refused to lower down the rail and staff to encourage the resident to lower down the rail.

A review of the resident's clinical record revealed that there was no assessment completed for the current use of rail by the resident. Interview with PSW #130 revealed that the resident uses the rail for mobility and positioning.

A review of the home's policy #VII-E-10.20, entitled "Bed Rails", revised June 2016, indicated there is an individualized approach to assess a resident's use or removal of bed rails. Not all residents required a bed rail, if a bed rail has been determined to be necessary, steps should be taken to reduce the known risks. The RN or RPN will assess residents' need for the use of bed rails, and document in the plan of care the resident's need for bed rails, including the number of rails to be used. The restraint/ Personal Assistance Services Device (PASD) assessment must be completed to identify the device as either a restraint or PASD.

Interview with RPN #131, #132, and RAI Coordinator confirmed that when the home had full rails for residents, they were completing assessments for them. At present moment, there are no residents in the home using full bed rails. Since the home has removed full bed rails, most of residents in the home are using quarter or half rails. There is no assessment completed for them. [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.

Observation on August 17, 2016, at 1330 hours revealed resident #071 was using the stairwell between two identified home areas. Interview with the receptionist revealed he/she was aware of two residents who were using the stairwell and they were given the door code. Interview with the acting DOC staff #103 revealed residents who prefer to use the stairwell are assessed by PT and occupational therapist (OT) for safe use of the stairwell. Interview with PT revealed there were 13 residents who were using the stairwell, and they were assessed for safety and capability after the discussion with the inspector. A review of five of the 13 residents' care plans revealed three care plans did not indicate the use of stairwells by the residents.

Interview with the acting DOC confirmed that the plan of care of the residents who were using the stairwell was not based on an assessment of the residents and their needs and preferences. [s. 6. (2)]

3. Observation on Aug 11, 2016, 1403 hours revealed that resident #006's bed had one

identified partial rail in the up position.

Interview with PSW #133 revealed resident #006 used the bed rail for mobility and positioning and it did not prevent the resident from getting out of bed. A review of the current MDS assessment, revealed that the resident was using bed rails for bed mobility and transfer. A review of the resident's written care plan did not indicate the resident was using bed rails for mobility and transfer or if it was his/her preference.

A review of the home's policy #VII-E-10.20, entitled "Bed Rails", revised June 2016, indicated there is an individualized approach to assess a resident's use or removal of bed rails. Not all residents required a bed rail, if a bed rail has been determined to be necessary, steps should be taken to reduce the known risks. The RN or RPN will assess residents' need for the use of bed rail, and document in the plan of care the resident's need for bed rails, including the number of rails to be used; the restraint/ Personal Assistance Services Device (PASD) assessment must be completed to identify the device as either a restraint or PASD.

Interviews with RPN #131, #132, and RAI coordinator confirmed that when the home applied full rails for residents, they were indicated in the written plan of care if they were considered a restraint or not. Since the home implemented the practice no full bed rails to be used, the quarter and half rails used for bed mobility, turning and repositioning are not necessarily documented in the written plan of care if they are not considered as a restraint. [s. 6. (2)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A Critical Incident Report (CIS) was submitted to Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2016, in regards to alleged resident to resident sexual abuse between resident #074 and resident #075.

A review of resident #074's progress notes revealed on an identified date, resident #074 was observed engaging in an identified act with resident #075. The progress notes further revealed that month later, an identified staff noted resident #074 touching resident #075 inappropriately, in a public location of the home.

A review of resident #074's CCAC admission documents from an identified date,

revealed the resident had a history of identified inappropriate sexual behaviours with specific interventions outlined. A review of resident #074's written plan of care did not describe resident #074's sexual behaviour.

Interview with registered staff #151 revealed resident #074's inappropriate sexual behaviour was noted not only with resident #075 but with other residents such as resident #076. The registered staff did not report the behaviour of resident #074 because they thought it was consensual by the other resident who was involved.

Interview with NM staff #125 revealed unawareness that resident #074 was engaging in an identified act with several residents in the home since this was not reported by registered staff. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary.

Resident #013's care plan included an impaired vision focus and identified interventions regarding the use of eye glasses. During interviews with PSW #115 and registered staff #112, both stated that although the resident wore glasses initially upon admission, the glasses had since broken and a decision was made by the resident’s family not to have them replaced. The inspector observed that the resident did not wear glasses during the inspection.

The acting Director of Care (DOC) stated expectation is that resident's care plan is kept up to date. [s. 6. (10) (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 there is a written plan of care for each resident that sets out the planned care for the resident, 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, staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (4) The licensee of a home to which subsection (2) or (3) applies shall ensure, not later than six months after the day this section comes into force, that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain everything required under clauses (1) (a), (b) and (c). O. Reg. 79/10, s. 19 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain the heating system, emergency lighting in hallways, corridors, stairways and exits and essential services required in the legislation.

A complaint submitted to MOHLTC indicated during a power outage the home did not have an operational generator within three hours to maintain essential services. Critical Incident Report from an identified date in June 2015, submitted to MOHLTC indicated that there was a power outage for four hours and 45 minutes and the home did not have operational generator within three hours to maintain the essential services.

According to previous inspection #2014_357101_0041, the home was found to be non-compliant by the MOHLTC under section 19(4) for not having access to a generator that was operational within three hours of a power outage that could maintain power to all essential services listed under the legislation and a voluntary plan of correction (VPC) was issued.

During this RQI and intake inspections, record review revealed that the following incident regarding a power outage was documented and noted to have a negative impact on the regular functioning of the home.

On an identified date in June 2015, there was a power outage in the Home. At the onset, the home alerted their contracted generator supply company about the power outage at approximately 1700 hours. At approximately 2115 hours the home alerted the contracted generator supply company that the power was still out, and that they would decide on ordering a generator at 2200 hours, five hours after the onset of the power outage. At 2246 hours, the company documented that they were notified by the home that the power had been restored. During this incident of power outage, residents were left without power to essential services such as dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment, for approximately five hours and 45 minutes. There was no harm to residents. The Director of Environmental Services #110 (DEVS) stated during an interview, that the home's current generator provides only enough power to maintain the emergency lighting in the home, and that it does not supply power to essential services in the home. The home did not have access to a generator that was operational within three hours.

During an interview with the representative #171 from the contracted generator supply company, he/she stated that overall they try to get a generator on site in four to six hours; however on average their onsite delivery time is eight to ten hours. The representative also stated that the home's contract with the company does not state a required timeline for delivery of a generator to the home during a power outage; and that the contract only states that the availability of service and equipment shall be on a first come first serve basis.

The inspector also identified upon review of the identified contract for 2015 and electronic correspondence provided by the home's Senior Director of Building and Capital Assets #179, that the home did not ensure that there was guaranteed access to a generator that

would be operational within three hours of a power outage and that can maintain the heating system, emergency lighting in hallways, corridors, stairways and exits and essential services required in the legislation. [s. 19. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has guaranteed access to a generator that will be operational within three hours of a power outage and that can maintain the heating system, emergency lighting in hallways, corridors, stairways and exits and essential services required in the legislation, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On August 31, 2016, the inspector observed 15 filled orders of identified narcotics and controlled substances unsecured and left unattended on top of a medication cart in the home.

The inspector waited beside the medication cart for approximately 45 seconds before the registered staff #150 exited the closed medication room to attend to the unsecured narcotics and controlled substances left on top of the medication cart.

The home's Narcotic and Controlled Substances Administration Record policy # 04-07-10, dated June 23, 2014, stated that when a new order of a narcotic or controlled drug arrives, it must be kept locked in the narcotic bin with its Narcotic and Controlled Substance Administration Record until ready for use. Registered staff #150 accepted the new order of narcotics and controlled drugs, however the drugs were left unattended on top of the medication cart for an extended period. During an interview, the interim DOC #103 stated the expectation is that narcotics and controlled substances are locked away at all times by double lock in the medication cart.

The acting DOC stated during an interview, that the home's narcotics and controlled substances must be securely stored and double-locked in the medication cart provided at all times except when in use by a designated staff member. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

During an interview resident #011 expressed concerns that he/she was not treated with respect and dignity because a staff member did not respond when the resident requested with the registered staff #142 to discuss a complaint with the nurse manager. According to resident #011, on an identified date, he/she requested to speak with NM staff #173 regarding a device which was frequently sounding in the shared room and causing resident #011 to experience an elevated level of frustration. During a second interview the resident recalled an increased level of frustration as he/she stayed awake until approximately 0200 hours that night waiting to speak with the nurse manager. Registered staff #142 stated during an interview that the noise level from the identified device was quite loud and disturbing since it could be also be heard outside at the nursing station; and that on the same evening, the NM was called to discuss alternative interventions, and that he/she was also informed of the resident's request to speak with him/her to voice concerns related to this issue. NM #173 stated during a telephone interview, that he/she visited the unit while completing rounds later that evening; however they assumed that the resident was already asleep and decided not to visit the resident in the room. The resident was moved to another room one to two days after resident #011 reported the issue with the identified device to the unit registered staff.

During an interview with the acting DOC, he/she stated that the nurse manager should have taken the time to discuss and resolve the issues when notified therefore the

resident was not treated with respect and dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that residents are treated with courtesy and respect and in a way that fully recognizes their individuality and respects their privacy.

On an identified date, the inspector observed the following interaction between resident #066 and registered staff #113 during medication administration. The registered staff required to administer an identified medication in a specific manner to a resident who was seated in the combined dining/activity area on the resident care unit, at a table directly across from three residents and two other residents. The registered staff administered the identified medication to resident #066, using a specific technique leaving an identified body part exposed, while three residents in the immediate area observed the procedure.

During an interview following the procedure, the registered staff acknowledged that this was their normal practice for administering medications of this type. He/she also stated that the procedure should have been done privately to ensure the resident's privacy. The acting DOC #103 stated during an interview, that the expectation is that staff provide privacy during such procedures by taking the resident back to their room and closing the curtains or the door before exposing the resident for the purpose of administering medications of this type. [s. 3. (1) 8.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's Narcotic and Controlled Substances Administration Policy #04-07-10, dated June 23, 2014, stated that when a new order of a narcotic or controlled drug arrives, it must be kept locked in the narcotic bin with its Narcotic and Controlled Substance Administration Record until ready for use. In addition, the policy stated that all entries must be made at the time the drug is removed from the container.

On September 1, 2016, during a medication observation the inspector observed two discrepancies on the narcotics and controlled substance count log for two residents from the same nursing unit: Resident #064 was prescribed an identified medication every morning at 0800 hours; the number of tablets remaining in the medication cart was nine, however ten was written on the narcotics and controlled substances count log. During an interview with registered staff #150, he/she stated that they had forgotten to adjust the count and sign the count log after administering the prescribed dose of controlled substances. Resident #065 was prescribed an identified medication, the number of tablets remaining in the medication cart was fourteen, however fifteen was written on the narcotics and controlled substances count log. During an interview with registered staff #150, he/she stated that they had forgotten to adjust the count and sign the log after administering the prescribed dose of narcotic to the resident.

The Home's Director of Care stated during an interview that the expectation is that the number of tablets remaining in the medication cart and the numbers written on the narcotics and controlled substances count log should be equal at all times after each medication pass. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident Report (CIR) submitted by the home to MOHLTC on an identified date in August, 2014, indicated alleged abuse towards resident #053 by staff PSW #126.
For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,
"emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;
"verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident;
"physical abuse" means, subject to subsection (2), the use of physical force by anyone other than a resident that causes physical injury or pain.

A review of the home's investigation notes revealed that an identified staff #124 witnessed another staff #126 placing his/her hand over an identified part of resident #053's body and speaking rudely to him/her on an identified date. The home's investigation notes revealed that staff #126 confirmed that he/she placed his/her hand over an identified area of resident #053's body and spoke rudely to him/her on the identified date.

Interview with resident #053 revealed that he/ she can recall a staff member speaking rudely to him/her more than a year ago, but was unable to recall more details. The resident stated he/she did not feel well emotionally after the incident.
Interview with the staff #124 revealed that he/she witnessed staff #126 placing his/her hand over an identified part of resident #053's body and speaking rudely to the resident as he/she was passing by.

Interview with staff #126 revealed that resident #053 was very agitated on the identified date. Resident was swearing and kicking at the staff during day shift. Staff #126 confirmed that he/she spoke rudely to the resident, but denied using his/her hands on the resident in the identified manner.

A review of home's investigation notes and interview with the acting DOC revealed that staff #126 was disciplined for three days for verbal abuse which diminished the resident's sense of well-being, dignity or self-worth, and physical abuse towards resident #053, and attended retraining on abuse /neglect, employee conduct and personal support worker role description and then returned to work. [s. 19. (1)]

2. An identified CIS report was submitted to MOHLTC on an identified date, in regards to alleged resident to resident sexual abuse between resident #074 and resident #075.

A review of resident #074's progress notes revealed on an identified date, resident #074 was engaging in an identified act with resident #075. The progress notes further revealed one month later an identified staff noted resident #074 was touching resident #075 inappropriately in a public location of the home.

A review of resident #074's CCAC admission documents, revealed the resident had a history of inappropriate sexual behaviour. A review of the written plan of care and interview with NM staff #125 confirmed that resident #074's inappropriate responsive behaviour was not identified since the admission, until two months later, and interventions were not in place until three months after the admission.

A review of the Minimum Data Set (MDS) assessment indicated resident #074's Cognitive Performance Scale (CPS) showed cognition largely intact and resident #075's CPS had an identified level of cognitive impairment.

Interview with registered staff #151 revealed resident #074's inappropriate sexual behaviour was noted not only with resident #075 but with other residents such as resident #076. The registered staff did not report the behaviour of resident #074 because they thought it was consensual by the other resident who was involved.

Interview with NM staff #125 revealed that the home did not complete a capacity assessment by either the home's ethics committee or the Geriatric Mental Health Outreach Team (GMHOT) specialists after the incident to determine if resident #075 was able to provide consent in regards to the particular sexual interaction with other residents.
A review of resident #074's (GMHOT) report from an identified date revealed the resident is cognitively intact and he/she would benefit from identified recommendations and interventions.

A review of resident #074's written plan of care revealed specific interventions initiated after the GMHOT's assessment. Interview with registered staff RPN #150, #132, and #151 revealed that resident #074's behaviour was not identified since admission until two months later. Specific interventions and recommendations made by the GMHOT were not implemented until three months after the admission and the GMHOT assessment.

Interview with NM staff #125 revealed resident #074 had a history of inappropriate touching of other residents, and the home did not put interventions in place at admission to protect other residents from the potential sexual abuse. [s. 19. (1)]

WN #7: 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 risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

An identified CIS report was submitted to MOHLTC on an identified date, in regards to alleged resident to resident sexual abuse between resident #074 and resident #075 on an identified date in June, 2016.

A review of resident #074's progress notes and interview with registered staff #151 indicated the particular incident happened on an identified date.

Interview with ADOC staff #125 revealed she was not aware why the incident was not reported to Ministry of Health and Long Term Care (MOHLTC) immediately and confirmed the incident was reported two days after it has happened. [s. 24. (1)]

2. A review of an identified CIS report, on an identified date, revealed that the home identified an abuse incident that had caused an area of altered skin integrity on an identified area of resident #042's body on an identified date.

Interview with Nurse Manager (NM) staff #125 revealed that the home suspected resident to resident or staff to resident abuse and conducted an investigation but reported it to MOHLTC five days later because they were waiting for the result of the investigation to report it.

Interview with NM staff #125 revealed that the expectation of the home is to immediately report any type of suspected or alleged abuse to the resident and confirmed that this incident was not reported to MOHLTC immediately. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the 24-hour admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator.

A review of resident #074's 24-hour admission care plan revealed the resident was admitted on an identified date, and only two identified areas of the care plan related to the resident's care needs were created. A review of the Community Care Access Center (CCAC) admission documents revealed the placement coordinator indicated that the resident had a history of inappropriate sexual behavior.

Interview with NM staff #125 indicated the expectation is when a new resident is admitted to the home a 24-hour admission care plan should be created based on the CCAC admission documents, assessments, and family and resident interview.

A review of the 24-hour admission care plan and interview with NM staff #125 and registered staff #151 confirmed resident #074's admission care plan was not based on the assessments, re-assessments and information provided by the placement coordinator. [s. 24. (4)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that protocols for the referral of residents to specialized resources where required are developed to meet the needs of residents with responsive behaviours.

During an interview in stage one of the resident quality inspection, resident #051 revealed he/she did not feel safe in the home as he/she was physically abused by resident #052 on an identified date. Resident #051 indicated on multiple occasions resident #052 was verbally abusive toward him/her, but he/she could not recall details of those incidents.

A review of resident #051 and #052's progress notes revealed that on an identified date, resident #051 was punched on an identified part of his/her body by resident #052 in the main lobby while watching TV. Resident #051 did not acquire any injuries.

A review of resident #052's progress notes and interviews with RPN #119, #120, #118, and PSW #123 revealed multiple incidents of verbal aggression including verbal threats toward co-residents on an identified date. Prior to the documented identified incident, resident #052 exhibited verbal aggression and was threatening towards other co-residents on three occasions. At a later date, resident #052 had another incident of physical aggression towards resident #020, when resident #052 was observed hitting the resident on an identified area of his/her body.

A review of resident #052's written plan of care revealed the resident had an identified behaviour problem related to a specific diagnosis and history of physical aggression. Multiple interventions were identified to manage the resident's responsive behavior.

A review of the home's Responsive Behaviors Management Policy # VII-F-10.20, revised January 2015, stated the following: registered staff will conduct and document a responsive behavior assessment/referral; whenever there is a change or concern about the resident's responsive behaviors, to evaluate the effectiveness of a planned intervention on the care plan that is addressing specific responsive behaviors; refer to available resources in the home or healthcare community resource such as Behavioral Support Team (BSO) or Behavioral Intervention Response Team (BIRT) if available or other similar type community team. Psycho Geriatric Resource Team and /or Psycho Geriatric resource team/or Psycho geriatric Resource consultant (PRC) and (EC).

A review of resident #052's clinical record indicated no referral for assessment by the Geriatric Mental Health Outreach team (GMHOT) to manage responsive behaviors after the above mentioned verbal and physical altercations. Resident #052's plan of care was also not reviewed to evaluate the effectiveness of current interventions since an identified date.

Interview with the ADOC #115 and RPN #119 confirmed that resident #052 was not reassessed or referred to GMHOT for his/her physical and verbal aggressive responsive behavior. Resident's current plan of care was not reviewed and revised for one year, and the interventions in place were not effective to respond to his/her responsive behaviours. [s. 53. (1) 4.]

2. The licensee has failed to ensure that a written record was kept related to the evaluation of the responsive behaviour program that included the following: date of the evaluation, summary of changes made and the date that those changes were implemented.

A record review of home's annual evaluation of the responsive behaviour program for 2015 and interview with the acting DOC confirmed that the date of evaluation, summary of the changes made and the date that those changes were implemented, were not documented in the evaluation. [s. 53. (3) (c)]

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

Findings/Faits saillants :

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

An identified CIS report was submitted to MOHLTC, in regards to an alleged/suspected sexual abuse of resident #040 by staff #156.

A review of the home's investigation record revealed the police were not notified in regards to the alleged/suspected sexual abuse.

A review of the home policy Prevention of Abuse and Neglect of a Resident, # VIIG-10.00, revised April 2014, states to immediately notify police for any alleged, suspected or witnessed incident of abuse.

Interview with Nurse Manager staff #125, #135 and acting DOC, revealed the expectation is the home to call the police for any alleged or suspected abuse and confirmed that the police was not called at the time. [s. 98.]

WN #11: 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 are administered to residents in accordance with the directions for use specified by the prescriber.

During a medication administration observation on August 17, 2016, the inspector observed a discrepancy between the number of tablets of an identified medication remaining in the medication cart and the narcotic and controlled substance count log. There were three identified tablets remaining in the medication cart, and two tablets recorded on the narcotics and controlled substance sheet. During an interview with registered staff #106, he/she stated that they had forgotten to administer the identified tablet to resident #063 at the prescribed time at 0800 hours. The tablet was administered to the resident at 1430 hours, which was 6.5 hours later than the prescribed time for administration. [s.131. (2)]

Issued on this 22nd day of December, 2016

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

Original report signed by the inspector.