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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 6, 2018	2018_694166_0007	004385-18	Resident Quality Inspection

Licensee/Titulaire de permis

Royal Canadian Legion District 'D' Care Centres
59 Lawson Rd TORONTO ON M1C 2J1

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

Tony Stacey Centre for Veterans' Care
59 Lawson Road TORONTO ON M1C 2J1

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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194), CRISTINA MONTOYA (461)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 12, 13, 14, 15, 16, 19, 20, 21, 22 2018

Log# 017655-16, Critical Incident Report(CIR)related to allegations of resident to resident abuse,
Log# 020308-16, Complaint related to the licensee's response for an admission to the home,
Log# 022418-16, CIR related to allegations of staff to resident abuse,

Log# 023552-16, CIR related to allegations of visitor to resident abuse,
Log# 026766-16, Complaint related to the licensee's response regarding a rejection letter for admission to the home,
Log# 028121-16, CIR related to a resident fall, resulting in injury,
Log# 028451-16, Complaint related to resident care,
Log# 029373-16, Complaint related to resident care,
Log# 029507-16, CIR related to allegations of staff to resident abuse,
Log# 031340-16, Complaint related to resident care,
Log# 007414-17, CIR related to an improper transfer, resulting in injury,
Log# 011604-17, CIR related to a fall, resulting in injury,
Log# 015788-17, CIR related to a fall, resulting in injury,
Log# 018170-17, Complaint related to resident care,
Log# 026125-17, CIR related to an improper transfer, resulting in injury,
Log# 029370-17, CIR related to a fall, resulting in injury,
Log# 029370-17, CIR related to allegations of resident to resident abuse,
Log# 000179-18, Follow up to Order #001 related to medication.
Were all inspected concurrently during this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, President of the Residents' Council, Resident Assessment Instrument Coordinators(RAI), Physiotherapist(PT), Registered Dietitian(RD), Food Service Manager(FSM), Environmental Manager(ESM), Maintenance staff members, Reception, Recreation Manager, Activity Assistant, Resident Care Nurse Managers (RCNM), Personal Support Workers(PSW), Registered Practical Nurses(RPN), Registered Nurses(RN), Director of Care(DOC) and the Executive Director(ED).

During the course of this inspection, the inspectors toured the home, resident rooms and common areas, observed staff to resident interactions during the provision of care, observed resident to resident interactions, snack and meal service, medication administration, infection control practices, reviewed clinical records, the licensee's investigations documentation and relevant policies related to this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 135. (3)	CO #001	2017_630589_0017	194

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Related to Log #029374-17 for resident #034

A Critical Incident Report (CIR) was submitted to the Director for an allegation of resident to resident abuse.

Review of resident #034's most recent written plan of care at the time of this inspection, indicated that the resident had identified responsive behaviours. The written plan of care included a number of identified interventions.

During separate interviews conducted with PSW #126, RPN #121 and RCAM #112, the staff members indicated that resident #034 had specific interventions to mitigate the responsive behaviours. The staff members interviewed were unable to locate the documentation records related to these interventions.

The DOC confirmed that the BSO manager revised the resident’s written plan of care, but did not provide clear direction to staff related to the management of the interventions required to mitigate resident #034's responsive behaviours. The BSO manager was unavailable for an interview.

The DOC confirmed that the specific interventions to mitigate the resident #034's responsive behaviour were necessary and that the plan of care for resident #034 did not set out clear directions for staff related to those requirements for resident #034.

The licensee has failed to ensure the written plan of care related to responsive behaviours for resident #034, set out clear directions to staff and others who provided direct care to the resident. [s.6.(1)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other person designated by the resident,or substitute decision maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Related to log #018170-17 for resident #026

A complaint related to the care of resident #026 was submitted to the Director.

The complaint by the resident's SDM, alleged staff were not listening or responding to the care needs of resident #026 when the resident indicated not feeling well. The family member alleged vital signs were not taken, appropriate medication not given for the complaints of discomfort and the family's request for a specific laboratory test was not followed.

Review of clinical documentation related to resident #026's care and change in condition, indicated RN #112 had assessed resident #026 and appropriate interventions were initiated.

During an interview, RCNM #112, confirmed resident #026's SDM was not informed of

the resident's change in condition as well, the SDM was not informed that appropriate interventions had been initiated.

The licensee has failed to ensure that the resident, the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of resident #026's plan of care. [s.6(5)]

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

Review of the written plan of care and physiotherapy assessment for resident #016 indicated that a mechanical device was to be used for all transfers for this resident.

On a specified date resident #016 was observed by Inspector #194 being transferred from chair to bed by one staff, PSW #124.

PSW #124, indicated during an interview with Inspector #194, an awareness that resident #016 required the aid of a mechanical device for transfers. The PSW indicated during the interview that resident #016 was transferred with the assistance of one staff because the PSW felt the resident was at risk from falling.

Inspector #194, was in the room by the bed at the time of the transfer and did not identify any risk for falls for resident #016. During the interview, PSW #124 indicated, resident #016 was not routinely transferred using a mechanical device as indicated by the physiotherapist and the resident's plan of care.

On a specific date and time, PSW #122 and #123 were observed by Inspector #194 transferring resident #016 from a mobility device to bed using a 2 staff assist, side by side.

PSW #122 indicated to Inspector #194, of not being aware the resident required the aid of a mechanical device, indicating that the PSW had been trained by other PSW staff to transfer resident #016 without the use of a mechanical device.

PSW #123 indicated, having never used a mechanical device for transferring resident #016 and was not aware that the plan of care indicated transfers for this resident required the use of a mechanical device.

The licensee has failed to ensure that care set out in the plan of care, related to transfers for resident #016 was provided as specified in the plan.[s.6.(7)]

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

On a specified date, Inspector #461 conducted the following observations during the lunch meal service:

PSW #122, during the noon meal service was observed assisting resident #030 with the meal. A few minutes later, the resident was observed to be unable to initiate the meal intake independently and required PSW #122 to totally assist the resident the remainder of the meal.

PSW #117 was observed by the Inspector providing total feeding assistance to resident #028. RPN #114 who was present in the dining room, indicated to Inspector #461 that resident #028 needed to be totally assisted with meals, but not with fluids.

Resident #016 was observed by Inspector #461, drinking a bottle of nutritional supplement independently. The lunch tray, which consisted of a sandwich, a bowl of tomato soup, strawberry mousse, and a glass containing an unlabelled drink was placed on a night table out of resident’s reach.

RPN #109 indicated to Inspector #461 that the resident was usually fed by the staff in the morning when the resident went down to the dining room for breakfast. At a later time, Inspector #461 observed that resident #016’s lunch tray was removed from the resident’s room and placed on the tray cart. The meal appeared untouched.

Review of the Resident Assessment Instrument- Minimum Data Set (RAI-MDS) for resident #030, indicated that resident required one person assist with eating.

Review of resident #030’s written plan of care under the “Eating” section directed the staff to provide intermittent encouragement and physical assist when fatigued.

Review of the RAI-MDS for resident #028, indicated that resident required extensive assistance and one person assist with eating.

Review of resident #028's written plan of care under the "Eating" section directed staff "to provide supervision with minimal set up or assistance.

Review of the RAI-MDS for resident #016, indicated that resident required extensive assistance and one person assist with eating. The Resident Assessment Protocol (RAP) for Functional Rehabilitation Potential, indicated the resident needed extensive assistance for eating and that the care plan would be addressed. Inspector #461 was unable to locate a written plan of care and directions for the staff related to eating assistance for resident #016.

Separate interviews were conducted with PSW #101, RPN #102, and Registered Dietitian (RD) #103. PSW #101 indicated that staff had attempted to feed resident #016, but resident often refused the assistance. RPN #102, indicated that resident #016 required total feeding assistance with the meals, but was able to hold the bottle of supplement and drink independently. The RD indicated that resident #016 was able to feed independently.

During separate interviews with PSW #111 and Food Service Manager (FSM) #104, both staff indicated that resident #030's care needs had changed and required total feeding assistance.The FSM also indicated that resident #028 was placed at the total assist table because resident #028 needed total assistance with meals.

During an interview with the RAI Coordinator #107, the RAI Coordinator confirmed that resident #016 did not have a care plan for eating assistance. Residents #028 and #030's eating assistance have changed from the last RAI-MDS assessment, but the written plan of care had not been revised to reflect the change in the identified residents' care needs.

The DOC indicated to Inspector #461 that the home's expectation was to review and revise the care plans at a minimum quarterly, and anytime there was a significant change in a resident's health status.

The DOC confirmed that the plan of care related to the eating assistance level for residents #016, #028 and #030 were not revised when the residents' care needs changed.

The licensee has failed to ensure that residents #030, #016 and resident #028 were reassessed and the plan of care reviewed and revised at least every six months and at

any other time, when the residents’ care needs change or care set out in the plan is no longer necessary. 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 (i) the written plan of care for resident #034 and for all other residents who are supported by the BSO program, provides clear direction related to the management and monitoring of residents with responsive behaviours.
(ii)The licensee is also requested to ensure that residents, residents' substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care and that (iii) the plan of care is provided to resident as specified in the plan (iv) and residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, residents' care needs change, to be implemented voluntarily.

WN #2: 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 :

Every licensee of a long term care home shall ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state or repair.

During the initial tour of the building on March 12, 2018, Inspector #194 and #166 observed:

Corridors:

- the linoleum(flooring) that is attached to the wall in all corridors in resident home areas has become detached from the wall and a heavy build up of dust and debris was observed behind and on top of the pulled away linoleum. Due to condition of the linoleum these areas can not be thoroughly cleaned and disinfected.

-in all corridors, the space between wall and the handrail, where the sanitizing dispensers are located, the paint is bubbling, peeling and flaking away from the wood. Due to the condition of the painted wood these areas can not be thoroughly cleaned or properly sanitized.

Shower room :

-paint has peeled away from the base of the shower exposing the bare cement and can not be thoroughly cleaned or properly sanitized.
-toilet lid (shower room) was cracked and had been glued together creating a potential risk for infection as the toilet lid can not be thoroughly cleaned or sanitized.
-caulking around base of the toilet black/covered with debris, pulling away from the toilet base and can not be cleaned or properly sanitized.

Shower room:

-observed in this shower room, paint that has been chipped of the walls exposing dry wall. Due to the condition of the walls in this shower room these areas can not be thoroughly cleaned or properly sanitized.
-in the shower stall, it was observed that the finished had worn off the shower head, exposing the metal of the shower head.

Identified resident rooms:

- paint peeling away from the ceiling in the bathroom.
- bedside nightstand has a chipped top with sharp edges
- wall surfaces in the bathroom are chipped, there is piece of black plastic covering

ceiling in the bathroom. Baseboards in the bathroom in disrepair, noted patches of unpainted and rough plaster on the wall.
-ceiling around the water sprinkler broken apart, ceiling was not sealed around the sprinkler.
damage on the wall beside resident bed, bathroom has wall damage, and leaking tap
- the baseboard near where the resident sits has pulled away from the wall and debris has collected between the wall and baseboard.
- wall damage noted in bathroom and linoleum is coming apart at base of walls where dust/debris has accumulated.

These areas of disrepair create a potential risk to the health, comfort, safety and well being of residents and may negatively impact the ability of staff to clean effectively. [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 the home, furnishings and equipment are kept clean and sanitary and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

related to Log #007414-17 for resident #024

A Critical Incident Report was submitted to the Director, reporting an improper resident

transfer, that resulted in an injury to resident #024.

Review of the plan of care related to lifts and transfers for resident #024, indicated that 2 staff assist using mechanical device was required for all transfers.

On a specified date, PSW #120 transferred resident #024 independently without use of mechanical device or a second staff. The transfer resulted in resident #024 sustaining an injury.

An interview with PSW #120 was conducted by Inspector #194. The PSW indicated, resident #024 had insisted on being transferred by one staff on the date of the incident.

PSW #120 confirmed awareness that resident #024 required 2 staff assist with use of mechanical device for transfers but completed the transfer contrary to the intervention for transfers as directed in the resident's plan of care. The improper transfer resulted in resident #024 sustaining an injury.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #024.[s.36]

The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

related to Log #026125-17 for resident #018

A Critical Incident Report was submitted to the Director reporting a fall resulting in injury to resident #018.

Review of the Critical Incident Report documentation indicated, PSW #125 was positioning a transfer device under resident #018 when the resident slid from a mobility aid and fell to the floor.

Review of the licensee's investigation indicated RN #113 had received a report from PSW #125 that resident #018 had slid from a mobility aid to the floor, while the PSW was trying to position a transfer device under the resident prior to transfer. Resident #018 was transferred to hospital for further assessment.

During an interview, PSW #125 indicated to inspector #194 of being aware that resident

#018 required two staff to assist for transfer, which included the positioning of the transfer device before transferring.

Review of resident #018's plan of care and the physiotherapy assessments indicated that transfers for resident #018 were to be completed by two staff using a mechanical device.

The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #018. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented as part of the organized program of housekeeping under clause 15(1)(a) of the Act
(a) Cleaning of the home, including
(i) Resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces
(ii) Common areas and staff areas, including floors, carpets, furnishings, contact surfaces

and wall surfaces.

Interviews with the ESM and the ED were completed by inspectors #194 and #166 related to the cleaning processes implemented in the home during the course of this inspection. The ESM and the ED acknowledged that identified areas in the home were dirty and required additional cleaning processes to be implemented.

Review of the Residents' Council meeting minutes for February 2018 indicated areas of concerns included:
-shower room tiles are cracked, dirty and mouldy
-air vents are dirty
-bathrooms need to be cleaned and freshened daily

Observations by inspectors #166 and #194 were completed related to areas requiring cleaning within the resident areas of the home, during the course of this inspection.

Resident main activity/lounge in the lower level of the home:
- the seats of chairs were soiled and base/legs of the chairs were gritty and dirty

Corridors:
-dirt and debris along the baseboards of the floors in all corridors in the resident home areas
-build up dirt along all thresholds to resident rooms
-dirt and debris noted behind the emergency doors in all corridors
-spider webs noted in door frames of specific identified resident rooms
-wooden handrails were noted to have dried debris on the outer surfaces in numerous areas
- the garbage receptacles for the disposal of incontinent products and other refuse are kept at the end of each corridor in the residents home areas, this is a potential safety/infection control risk specifically for cognitively impaired residents

Resident common areas:
-dirt and debris noted on the floors, especially in the corners of the rooms and the base of the wooden divider areas
-window in an identified area is covered in dirt and spider webs

Identified Residents' rooms:
-floor in room, base of transfer pole as well as corners in the room were dirty. Floor in the

bathroom was dirty and sticky.
-floor in room and bathroom was dirty and sticky. Handle of transfer pole was dirty and sticky.
-floors in room and bathroom were dirty and sticky
- fan in room covered in dust
-floor in room and bathroom were dirty
-floor in bathroom and bedroom were dirty with build up of debris in corners of the room and entrance area
- garbage containers for the collection of incontinent products and other refuse were kept at the end of each corridor in a common area,
The practice of leaving garbage containers in resident accessible areas creates a potential safety/infection control risk to all residents but specifically to cognitively impaired residents.

These unclean areas may create a potential health and safety risk to residents related to resident well being and infection control. s.87.(2)(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 procedures are implemented for, cleaning of the home, including, (i)resident bedrooms, including floors, furnishings, contact surfaces and wall surfaces, and (ii) common areas including floors, furnishings, contact surfaces and wall surfaces; (iii) resident care equipment, such as tubs, shower chairs and lift chairs, (iv)supplies and devices, including personal assistance services devices, assistive aids and positioning aids and (v) removal and safe disposal of dry and wet garbage, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs used by or administered to a resident in the home had been prescribed for the resident.

Review of the Medication Administration Records (MAR) for residents #012 and #016 indicated that medications were being administered to the residents without being prescribed.

Related to resident #012

Inspector #194, reviewed resident #012's Medication Administration Record (MAR) and the physician's orders for a specific month. The MAR, indicated that resident #012 was to be administered three specific medications.

Review of the physician's orders for resident #012 indicated there were no current orders for these medications.

During an interview with RPN #109, the RPN verified that one of the medications was in the medication pouch for resident #012 and therefore had been administered to the resident.

During an interview, RPN #102, confirmed that the current three month review did not provide any current physician's orders for the three medications administered to resident #012.

Related to resident #016

Inspector #194 identified that resident #016 was being administered a nutritional supplement 4 times daily without a current order.

Review of the quarterly medication review, identified that resident #016 was to be

administered 1 bottle of nutritional supplement twice a day breakfast and lunch.

Interview with the Food Service Manager(FSM), indicated, resident #016 was being provided 1 bottle of nutritional supplement 4 times daily and 125 ml of nutritional supplement lunch and dinner as ordered by dietitian.

Interview with DOC was conducted by Inspector #194, related to the medication discrepancies identified for resident #012 and #016. The DOC indicated that upon review of the clinical health record for resident #012 and #016, it was noted that the medications for resident #012 and the nutritional supplement for resident #016 had previously been ordered for the residents but not transcribed onto the current quarterly medication review and therefore not reordered by the physician.

The DOC indicated the nurse manager and the pharmacist were responsible for initiating the quarterly medication review for residents but were not following the licensee's policy related to the process of reviewing current/ongoing and new physician's orders quarterly.

The licensee failed to ensure that drugs used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that medications that may be required for ongoing treatment are correctly transcribed to the current three month review, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The licensee policy "Abuse and Negligence" (#02-06) (effective date December 2016) communicates that 'Tony Stacey Centre for Veterans supports and promotes zero tolerance of abuse and neglect of the residents of our facility. Any instance of abuse or suspected abuse must be reported to the Executive Director or designate immediately".

The licensee's policy directs the staff to:

Anyone who has reason to suspect or believe a resident has suffered or is alleged to have suffered abuse must report these suspicions to the Charge Nurse immediately.

The Charge Nurse is to investigate immediately and report to the Nurse Manager or Director of Care their findings.

Whenever there is alleged or actual abuse by another resident, that resident will be assessed and removed from the immediate area if it is safe to do so. They will be interviewed by the Director of Care and Executive Director, or in their absence the most senior managers in the facility.

As part of the process they will:

Ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation immediately upon the completion of the investigation.

Notify the Ministry of Health and Long Term Care according to legislation:

During each interview is important to:

- Establish the location of the incident
- The time of the incident
- Any witnesses
- The chronology of the incident – what happened leading up to the incident, during the incident and following the incident
- List any of all injuries depending on the type of abuse
- Document the interview
- Review the documentation with the interviewee
- Have employees document what, where, when, who, and why for themselves in terms of their involvement or witness to the event.

Related to Log #029374-17 for resident #034, #035 and #012

A Critical Incident Report was submitted to the Director for an allegation of abuse between resident #034 and #035.

The resident's assessment related to behavioural symptoms, indicated that resident #034 had been observed exhibiting responsive behaviours.

Review of resident #034’s progress notes indicated two separate allegations of responsive behaviours by resident #034 directed towards resident #035 and resident #012:

During separate interviews with RCNM #112 and the DOC, the RCNM indicated that resident #012 approached the RCNM, regarding resident 034's responsive behaviours. The DOC and RCNM confirmed, the incident should have been immediately reported to the Director.

The licensee failed to ensure that its policy for “Abuse and Negligence” (#02-06) (effective date December 2016), was complied with, specifically related to immediately reporting the allegations resident abuse. [s. 20. (1)]

Related to Log #006072-18 for resident #012

A Critical Incident Report was submitted to the Director regarding to an allegation of a staff to resident abuse involving resident #012 reported to Inspector #461 during this inspection.

Resident #012 indicated to inspector #461, that the resident had requested PSW #131 to assist with a shower. Resident #012 indicated that PSW #131 with a raised voice commented that resident #012 was on another PSW's work list and that the resident was giving PSW #131 more work.

PSW #131 did give resident #012 a shower while repeatedly saying to resident "I will never do this again". Resident #012 asked PSW #131 to stop saying that because it made the resident feel angry and upset.

Resident #012 further indicated, that the next day the resident overheard PSW #131 complaining to other PSWs about having to give resident #012 a shower the night before, when it was another PSW's assignment.

Resident #012, informed the inspector that PSW #131's behaviour and comments were disrespectful. Resident #012 indicated having reported the incident to RCNM #130.

Inspector #461 immediately reported incident to the DOC, who was not aware of the allegation of staff to resident abuse.

During an interview with inspector #461, PSW #131 indicated that resident #012 was not a part of this PSW's assignment and to shower the resident was adding more work for PSW.

During an interview with inspector #461, the DOC indicated RCNM #130 should have initiated an incident report related to the alleged abuse, reported the incident to the DOC and notified the Director.

The licensee failed to ensure that its policy for "Abuse and Negligence" (#02-06) (effective date December 2016), was complied with, specifically related to immediately reporting the allegations of resident abuse. [s. 20. (1)]

Issued on this 18th day of May, 2018

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

Original report signed by the inspector.