Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2019	2019_549107_0013	012945-19, 014006-19, 014029-19, 014585-19, 015067-19, 016123-19, 016471-19, 016608-19, 017012-19, 017013-19, 017471-19, 017833-19, 018505-19, 018605-19, 018877-19	Critical Incident System

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

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

MICHELLE WARRENER (107), CAROL POLCZ (156), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 30, October 1, 2, 3, 4, 8, 9, 10, 15, 16, 17, 18, 21, 22, 23, 24, 25, 2019. Off site inspection on October 28, 29, 2019 by telephone.

The following intakes were completed during this Critical Incident System inspection:
Log#014029-19, CIS#2779-000062-19 related to a medication incident
Log #015067-19, CIS#2779-000067-19 related to resident to resident responsive behaviours
Log#017012-19, CIS#2779-000077-19 related to resident to resident responsive behaviours
Log #012945-19, AH IL-68028-AH/CIS#2779-000053-19 related to alleged staff to resident abuse
Log #017013-19, CIS#2779-000078-19 related to alleged staff to resident neglect
Log# 017471-19, CIS#2779-000083-19 related to alleged staff to resident neglect
Log#014006-19, CIS#2779-000060-19 related to alleged staff to resident neglect
Log# 016123-19, CIS#2779-000070-19 related to alleged staff to resident neglect/improper care
Log#018605-19, CIS#2779-000088-19 related to improper transfer of a resident
Log#016608-19, CIS#2779-000073-19 related to improper transfer of a resident
Log#018505-19, AH IL-66641-AH/CIS#2779-000037-19 related to improper transfer of a resident
Log#018877-19, CIS#AH IL-70705-AH/ CI 2779-000089-19 related to improper transfer of a resident
Log#017833-19, CIS#2779-000085-19 related to improper transfer of a resident
Log#016471-19, CIS#2779-000071-19 related to unplanned evacuation
Log#014585-19, CIS#2779-000065-19 related to safe and secure home

PLEASE NOTE: A written notification and Compliance Order related to s. 19(1), and O.Reg. 79/10, s. 71 (3)(a); A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6 (7), and s. 24(1)2; and a written notification related to LTCHA, 2007, c.8, s. 23(2) and O.Reg. 79/10, s. 40, identified in a concurrent inspection #2019_549107_0014(Log #017703-19, 020431-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with The Executive Director, Director of Clinical Services, Director of Culinary Services, Food Services

Supervisor, Registered Dietitian, Director of Environmental Services, Employee Services Coordinator, Associate Directors of Clinical Services, registered nursing staff (Registered Nurses, Registered Practical Nurses), Personal Support Workers, Nursing Consultant, Physician, Dietary staff, Housekeeping staff, residents, and family members.

Inspectors toured the home including an outdoor courtyard, made observations of windows and door security, care provided to residents, resident environments and equipment used by residents, medication administration, meal service, food production, reviewed clinical records, licensee's policies, investigative notes made by staff and other documents maintained by the home

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **25 WN(s)**
- **14 VPC(s)**
- **7 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home provided a safe and secure environment for its residents.

The licensee notified the Director, through the Critical Incident System (CIS), that the home had not provided a safe and secure environment for resident #010. The home's investigative notes, including clinical information, and the above noted CIS report, indicated that resident #010 was repeatedly demonstrating responsive behaviours and a safe and secure environment had not been provided resulting in risks to the resident.

On a specified date, Inspector #129 observed resident #010 in an environment that was not safe and secured. This information was shared with the Director of Environmental Services (DES) #109 who indicated that they would ensure that a safe and secure environment was maintained.

A review of the findings from inspection #2019_539120_0021, completed on July 11, 2019, by Inspector #120, indicated that the licensee had failed to comply with this legislative section (LTCH Act, 2007, c. 8, s. 5), in-part due to the failure to provide a safe and secure environment. The above noted report indicated the Inspector directed the home to prepare a written plan of corrective action for achieving compliance and ensuring the home provided a safe and secure environment for its residents.
During a discussion with the DES, they acknowledged that they recalled the above noted inspection report. The DES was asked what plan the home had put in place to ensure the safety of the residents. The DES indicated that at the time of the previous inspection staff were instructed to ensure a secured environment was provided but a written plan of corrective action had not been created to ensure the environment remained safe and secured.

The licensee failed to ensure resident #010's environment was safe and secure when they became aware the resident demonstrated responsive behaviours.[s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle included alternative beverage choices at meals.

The planned menu cycle, including the therapeutic extension menus available for review by Inspector #107, did not include any beverages to be offered to residents, with the exception of juice.

A. Resident #040 had a plan of care that required thickened consistency beverages. At an observed meal service, resident #040 was provided thickened water and juice and was not offered thickened milk. The resident told Inspector #107 that they enjoyed milk and had not refused milk at the meal.

During an interview with Inspector #107, Dietary Aide #126, who was serving the meal, stated that milk was not identified on the therapeutic extension menu and that staff did not serve thickened milk to residents unless it was on the menu or ordered with a label for each specific resident.

At an observed meal service the next day, resident #040 was provided the same fluids as at the day before (juice and water) and a thickened hot beverage, and was not provided

thickened milk at the meal. The resident told Inspector #107 that they enjoyed milk and PSW #106 and RPN #104 confirmed the resident had not received milk at the meal.

The serving list that dietary and nursing staff used to portion meals and beverages did not indicate the resident disliked milk.

During interview with Inspector #107, the Registered Dietitian #157, and Nutrition Manager #156, confirmed that resident #040 would not ask for milk but would be able to accept/decline if it was offered.

B. Dietary Aide #138 portioned a meal for resident #031. According to the serving list, the resident required thickened consistency fluids. The resident was provided with thickened water and juice. Thickened milk was not included in the meal portioned for the resident. The serving list did not identify that the resident disliked milk.

Dietary Aide #138, who was serving the meal, stated that the menu only indicated assorted juices. The Dietary Aide stated that they used to portion out the thickened milk in the kitchen but they didn't anymore. Thickened milk was available in purchased pre-thickened containers, however, was not readily available in the servery. The Dietary Aide stated that staff did not provide thickened milk unless it was in the specials with a specific label for each resident.

The planned menu and therapeutic extension menus did not include or direct staff to offer milk with meals resulting in reduced choice of beverages and reduced nutritive value of the meals served to the identified residents. [s. 71. (1) (d)]

2. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

A. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for in incident that occurred in the home. The report alleged that resident #007 was not offered or provided two meals on the same day. Inspector #107 attempted to interview the resident, however, the resident was not interviewable.

Investigative interview notes, completed by ED #100 and the Director of Clinical Services (DCS) #101, identified that PSW #159 and PSW #161 were aware that resident #007 was not offered two meals in one day, they took no action to provide food for the resident, and the incident was not reported to management prior to leaving the home at the end of

either staff member's shift.

During interview with Inspector #107, Executive Director #100 confirmed that resident #007 was not offered two meals on a specified date.

B. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for two incidents that occurred in the home. The report alleged that some residents were not served a meal on two specified days due to staffing shortages.

The home's investigative interview notes were reviewed during this inspection and identified the following information:

RPN #107 identified that six residents were in bed at the meal on the first specified date, and confirmed that there was no food on the snack cart that day. RPN #107 stated that the residents in bed were offered food when the nourishment cart went around and all of the residents refused the food that was offered. The Executive Director #100 confirmed that trays had not been provided to residents who had not come to the dining room for the meal.

During interview with Inspector #107, PSW #162 identified that resident #035 was in bed during the meal on the first identified day and the resident would not have been able to agree or disagree to the choice of food at the snack pass. RPN #107 stated during interview with Inspector #107, that resident #035 was provided a small amount of additional nutritional supplement at the snack pass and was not provided with a meal.

In the interview notes for the second date, RPN #112 identified that nine residents were still in bed during the meal due to staffing issues and that residents were offered food from the snack cart. It was unclear if food was available on the snack cart that day. PSW#162 who completed the snack service stated during interview with Inspector #107, that there was no food on the snack cart that day, however PSW #127, who was also working that day, stated that food was available on the snack cart.

During interview with Inspector #107, PSW #127, who was working in the identified home area on both day, stated five residents (#047, #005, #048, #035, #012) were in bed at the meal on the first date, and that eight residents (#012, #035, #049, #050, #048, #047, #005, #006) were in bed at the meal on the second date. PSW #127 stated that residents that required a higher level of care remained in bed as they did not have time to get the residents up. PSW #127 stated the usual practice when they were fully staffed to

the usual staffing complement was to wake residents up and take them to the dining room for the meal. PSW #127 confirmed that staff did not wake the residents up or ask the residents if they wanted to go to the dining room on the two identified dates, due to staffing shortages. PSW #127 stated that some of the residents routinely did not come for the meal but that other residents routinely came for meals and had not been awakened to offer the meal due to staffing shortages.

Not all residents were offered a meal on two identified dates due to staffing shortages below the usual staffing complement. [s. 71. (3) (a)]

3. The licensee failed to ensure that the planned menu items were offered to residents at two observed meals.

The planned lunch menu for both meals included soup.

At an observed meal, residents #036, #003, #037, and #012, were not offered soup. Inspector #107 observed that other residents in the dining room were eating soup and the offering of soup had ended. Soup was not observed for any of the identified residents. Two of the residents confirmed to Inspector #107 that they had not been offered soup. Resident #036 stated they would like some soup if it was offered.

PSW #129 stated to Inspector #107 that they assumed the other person working with them had taken the residents' preferences for soup and confirmed the residents were missed. When PSW #129 offered soup to the residents, two of the four residents accepted the offer of soup at the meal.

At another observed meal, PSW #129 came and asked resident #012 if they had been offered soup and the resident stated they had not been asked. The soup course had ended and residents in the rest of the dining room were receiving their entrees at the time. The resident had not come late to the dining room.

Not all residents were consistently offered soup as per the planned menu. [s. 71. (4)]

4. The licensee failed to ensure that an individualized menu was developed for each resident whose needs could not be met through the home's menu cycle.

The care plan for resident #032 indicated that the resident was assessed at nutritional risk and that they required an individualized menu.

During a meal observation by inspector #156, resident #032 was not offered part of the meal. It was later confirmed with Dietary Aide #126 and PSW #129 that the resident did not receive the menu item because it was incompatible with the resident's dietary restrictions and the home had not prepared an item that was suitable for the resident's diet plan.

When it was time for dessert, there were two options on the regular menu. The resident was not offered one of the choices because of their dietary restrictions. The resident was provided with the other choice. Dietary Aide #126 indicated that the home did not prepare a suitable second choice of dessert for the resident, however, Dietary Aide #126 reported that the resident would be provided applesauce as an option if the dessert offered to the resident was declined.

On the same date, the Inspector spoke with Cook #137 and Dietary Aide #138 to clarify the individualized menu. Both staff confirmed that the resident had an individualized menu until the regular menu changed, approximately two months prior. Since the implementation of the new menu, and a new Registered Dietitian, the resident did not have an individualized menu, as confirmed with staff. [s. 71. (5)]

Additional Required Actions:

CO # - 002 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 with O.Reg. 79/10, s. 71 (1) (d) Every licensee of a long-term care home shall ensure that the home's menu cycle, includes alternative beverage choices at meals and snacks, and
with O.Reg. 79/10, s. 71 (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that meals were served in a congregate dining setting unless a resident's assessed needs indicated otherwise.

A. On a specified date, Inspector #107 observed PSW #129 bringing a tray back from resident #007's room. PSW #129 stated that they were short staffed that day so the resident was fed in bed due to staffing shortages.

B. On another specified date, Inspector #107 observed PSW #129 carrying a meal tray down the hall of an identified home area. The PSW confirmed that the tray was for

resident #041 and stated that they were short a PSW that day so the resident was left in bed due to the staffing level. The PSW confirmed that the resident was not approached or asked if they wanted to go to the dining room.

Inspector #107 spoke with resident #041 the same day and the resident told Inspector #107 they had wanted to go to the dining room for the meal but that there wasn't enough staff to get the resident up so they had to stay in bed for the meal.

RPN #112 confirmed to Inspector #107 that resident #041 was left in bed for the meal due to staffing shortages below the planned staffing complement. [s. 73. (1) 3.]

2. The licensee failed to ensure that the home had a dining service that included sufficient time for every resident to eat at their own pace.

The evening meal was scheduled for 1700 hours. During interview with Inspector #107, Dietary Aide #126, who was serving in the dining room, stated that they usually cleared the food out of the steam table by 1730 hours as the kitchen staff were wanting to wash up the dishes.

At an observed supper meal, resident #036 left the dining room at 1750 hours without eating. The resident told Inspector #107 that they did not like their meal and, when asked by the Inspector, the resident stated they would like to try the second meal choice. When Inspector #107 communicated the request of resident #036 to PSW #119, the PSW informed the Inspector that the food had been discarded from the steam table. A meal was eventually found for the resident but was not readily available. PSW #119 expressed concern to Inspector #107 that the food was routinely cleared out of the steam table early and not kept in the steam table for the full meal service. [s. 73. (1) 7.]

3. The licensee failed to ensure that course by course service of meals was provided to resident #024.

On a specified date, Inspector #107 observed resident #024 eating soup while a plate of food (hot meal type items) was sitting on the table beside the resident. Resident #024 confirmed that the plate was theirs and that they had not asked for the food to be placed on the table while they were eating their soup.

The licensee's policy, "Pleasurable Dining" Section 5.3, effective date May 2017, directed staff to serve meals course by course unless otherwise indicated by the resident or by

the resident's assessed needs and documented in the resident's care plan.

The plan of care for resident #024 did not include the provision of the entrée at the same time as the resident was served their soup.

Course by course meal service was not offered to resident #024 at the observed meal service. [s. 73. (1) 8.]

4. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A. Staff did not use safe positioning of resident #035, who required assistance with eating and drinking at two observed meals.

At an observed meal service, resident #035 was tilted back in their wheelchair and PSW #155 was providing total assistance with the resident's meal. The resident's chin was extended towards the ceiling and the resident was not in an upright position during the meal.

Inspector #107 asked PSW #155 about the positioning of the resident and the PSW put the resident in an upright position for the remainder of the meal.

The plan of care for resident #035 directed staff to ensure that the resident was positioned upright for eating.

At another observed meal, resident #035 was not positioned safely in their wheelchair while they were being assisted with eating. The resident's chin was extended slightly upwards toward the ceiling and the resident's head was well below their head rest.

The PSW assisting the resident confirmed the resident's wheelchair was in an upright position, however, the resident was not re-positioned to maintain an upright position during the meal.

B. At an observed meal, resident #034, who required assistance with eating, had their wheelchair in a tilt position during the meal. The resident was leaning forward in their wheelchair during the meal to maintain an upright position.

During interview with Inspector #107, PSW #145 confirmed that the resident required

their wheelchair to be in an upright position during meals and the wheelchair was not to be tilted at meals. [s. 73. (1) 10.]

5. The licensee failed to ensure that residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required by the resident.

1. Residents #012, #036, #037, and #003 were served a meal without having someone available to provide assistance with eating at three observed meal services.

The seating plan identified a PSW was assigned to provide assistance with eating at an identified table. The PSW "dining room assignments", that were posted in the dining room, outlined the duties of each PSW during each meal service. On that list, the same PSW was assigned to duties other than assisting residents with eating. The two documents were inconsistent.

During interview with PSW #129, the PSW confirmed they were the PSW assigned to that position, however, they confirmed they did not assist residents with eating at the identified table. The PSW stated they followed the assignment list which identified they were scheduled to serve meals and clear tables.

During interview with the Director of Clinical Services #101, the Food Services Supervisor #156, and Registered Dietitian #157, they were unaware of the discrepancy between the seating plan and dining room assignment sheets regarding whether staff were to assist residents at the identified table.

A. The plan of care for resident #003 identified the resident was at nutrition risk and required extensive assistance with eating, with some assistance needed at most meals. The resident had a significant weight loss over five months. The resident had a weight which was below their goal weight range and below their ideal body weight range, as identified in Point Click Care.

At an observed meal, resident #003 was seated at the identified table in the dining room. The resident's meal was placed on the table before any staff were at the table. The resident sat with their meal in-front of them not eating for almost the entire meal service. The resident had not eaten anything and staff briefly provided verbal encouragement to the resident which was unsuccessful. During interview with Inspector #107 after the meal about the resident's level of assistance, PSW #125 stated that resident #003 just

picked at their meals.

At another observed meal, resident #003 had a meal placed in-front of them and no assistance was provided to the resident until a staff member briefly sat down to assist the resident. The resident had not been eating the meal. Inspector #107 noted that the staff that had been sitting at the identified table was now assisting at a different table. Resident #003 was observed dipping their index finger into their meal to try to eat it. Staff had not returned to assist at the identified table other than to assist resident #012 after Inspector #107 had informed them that resident #012 had requested assistance. Resident #003 was sleeping at the table and also hadn't consumed their beverages.

At another observed meal, resident #003 was served a meal and was not assisted with the meal. The resident had not eaten. During interview with PSW #129 after the meal the PSW stated that resident #003 needed more assistance. PSW #129, who was assigned on the seating plan to assist at the identified table, confirmed they had not assisted at the table, however, thought PSW #160 provided assistance to the residents at the identified table. PSW #160 stated they were assisting at a different table and only provided very limited assistance to the residents at the identified table during the meal.

B. The plan of care for resident #036 identified the resident was at nutrition risk and required extensive assistance with eating. The plan of care indicated that they required assistance with most meals. The resident had a significant weight loss recorded over three months. The resident had a weight which fell below the resident's goal weight range and their ideal body weight range, as identified in Point Click Care.

At an observed meal, resident #036 was seated at the identified table in the dining room. Resident #036 had their meal placed on the table and staff did not come to assist the resident when the meal was placed on the table. Staff came to assist resident #036 briefly, however, left the table again and went to assist at a different table. The resident left the dining room without eating. When the resident was leaving the dining room, staff had not approached the resident to determine why they were leaving without eating. Inspector #107 asked the resident if they would like to try the alternative meal and the resident said yes. When Inspector #107 informed PSW #119 that the resident would like to try the alternative meal, PSW #119 sat down and assisted the resident with eating. During interview with Inspector #107 after the meal about the resident's level of assistance, PSW #125 stated that resident #036 used to eat independently but required more assistance with eating after a decline in their health.

At another observed meal, resident #036 left the dining room without eating. During interview with PSW #129 at the end of the meal, the PSW stated that resident #036 required more assistance due to a decline in their condition. PSW #129, who was assigned on the seating plan to assist at the identified table, confirmed they had not assisted at the table, however, thought PSW #160 provided assistance to the residents at the identified table. PSW #160 stated they were assisting at a different table and only provided very limited assistance to the residents at the identified table during the meal.

On another date, Inspector #107 observed resident #036 trying to eat their meal using their index finger. There were no staff sitting at the table and staff did not identify that the resident required assistance.

C. The plan of care for resident #037 identified the resident was at nutrition risk and required extensive assistance with meal set up. The resident had some gradual weight decline and was below their ideal body weight range, as identified in Point Click Care.

At an observed meal, resident #037 was seated at the identified table in the dining room. Resident #037 had their meal placed on the table for an extended period and staff did not assist the resident. The resident was not eating their meal. Approximately 20 minutes later staff came briefly to assist the resident and the resident started eating. During interview with PSW #129, the PSW stated that resident #037 required cueing to initiate eating.

D. The plan of care for resident #012 identified the resident was at nutrition risk and required extensive assistance with eating with some assistance at all meals.

At an observed meal, resident #012 was seated at the identified table in the dining room. Inspector #107 observed resident #012 sitting with their meal in-front of them not eating. The resident had been sitting with their meal in-front of them for approximately half an hour without assistance being offered. Resident #012 told Inspector they required assistance with their meal and were unable to cut up the food or pick it up and requested the assistance of Inspector #107. Staff were not seated at the table and had not identified the resident required assistance with their meal. The resident ate poorly at the meal.

At another observed meal, resident #012 was served their meal and assistance was not provided at that time to the resident. Almost an hour after the start of the meal, Inspector #107 noticed that resident #012 had not been eating. When asked by Inspector #107

why the resident was not eating the resident informed Inspector #107 that they required some assistance with eating. Inspector #107 informed PSW #136 who came and assisted the resident. (107)

2. During a meal observation by inspector #156, resident #015 was fully assisted with eating by PSW #136. Resident #031 had their food in front of them for 14 minutes until PSW #136 stopped feeding resident #015 and then started to feed resident #031. PSW #136 stopped and went back to resident #015 and assisted them with the rest of their meal, and then went back to resident #031 to assist them. Both residents sat for approximately fifteen minutes with their food in front of them and no assistance was provided.

The plan of care for resident #015 indicated that they were totally dependent on staff for the feeding; one staff was to physically assist the resident.

The plan of care for resident #031 indicated that they required extensive to total assistance of one staff for feeding.

The licensee failed to ensure that residents who required assistance with eating were not served a meal until someone was available to provide the assistance required by the resident. (156) [s. 73. (2) (b)]

Additional Required Actions:

CO # - 003 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 with O.Reg. 79/10, s. 73 (1) 3 Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #4: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A. Resident #009's Physician ordered the resident to receive specific medications during the day. The noted Physician's orders stipulated that the medication was to be held if the resident was not eating.

A review of clinical documentation made in the computerized clinical record confirmed resident #009 refused to eat a meal on a specified date, and the resident did not fully consume their next meal.

A review of the Medication Administration record indicated that RPN #102 administered the medication on the specified date when resident #009 had not eaten a meal and had not consumed their entire meal at the next meal service.

The licensee made a report to the Director, through the Critical Incident System (CIS), that indicated RPN #102 had administered the medication when the resident had not eaten an entire meal and when the resident had not fully consumed the next meal. The Critical Incident System (CIS) report, clinical notes, and other records maintained by the home, indicated that as a result of this incident, resident #009 experienced a negative outcome.

The licensee did not ensure that resident #009 was administered medications as specified by the prescriber when the resident was administered medications when they had not eaten an entire meal and had not fully consumed the next meal.

B. Resident #004's Physician ordered the resident to receive a specific medication twice

daily.

A review of a Medication Incident Report maintained by the home, clinical notes made by RPN #139, and a written statement to the Executive Director made by RPN #139, indicated that resident #004 was administered medication that had been ordered for a co-resident. Information in the above noted records indicated that RPN #139 had not properly checked the medication label or the identity of resident #004 prior to administering six times resident #004's usual dose of medication. The Physician and Pharmacist were contacted and RPN #139 was directed to monitor the resident for negative effects throughout the shift, as well as to report the incident to staff working the oncoming shift. Clinical notes indicated resident #004's condition did not change and there was not a need for additional actions related to the increased medication the resident received.

The licensee did not ensure that resident #004's medications were administered as specified by the prescriber when the resident was administered six times their ordered dose of medication.

The licensee failed to ensure that drugs were administered to resident #009 and resident #004 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with 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 failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

A. On a specified date, PSW #121 made statements to resident #011 that upset the resident.

Shortly after the incident, resident #011 reported the incident to RPN #120 and it was documented that the resident had a negative outcome. In an interview with RPN #120, they confirmed that the resident had negative feelings related to the incident. RPN #120 confirmed that the incident met the definition of verbal abuse.

In an interview with the Executive Director #100, they confirmed that the abuse allegation was founded. (506)

B. The licensee failed to ensure that residents were not neglected by the licensee or staff.

i. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for an incident that occurred on a specified date. The report alleged that resident #007 was not provided two meals on a specified date. Inspector #107 attempted to interview the resident, however, the resident was not interviewable.

Investigative interview notes, completed by ED #100 and the Director of Clinical Services (DCS) #101, identified that both PSW #159 and PSW #161 were aware that resident #007 was not offered two meals, the staff took no action to offer the resident a meal, and the incident was not reported to management prior to leaving the home at the end of either staff member's shift.

During interview with Inspector #107, the ED #100 confirmed that they had been working on the date of the incident, and was not informed of the incident on the day that it occurred and did not become aware of the incident until several days later.

PSW #119 was assigned to provide care to resident #007 on the specified date. During interview with Inspector #107, PSW #119 stated that they had not observed the resident in the dining room but had documented that the resident ate and drank at the identified meals, based on what was reported to PSW#119 from colleagues. Documentation on the resident's food and fluid intake records reflected the resident consumed sufficient fluids that day, however, without the fluids documented at the two meals, the resident's fluid intake would have been significantly below their minimum daily fluid requirement, as indicated in the resident's plan of care.

During interview with Inspector #107, Executive Director #100 confirmed that resident #007 was not offered two meals on a specified date. The Executive Director confirmed the allegations of neglect were founded.

Resident #007 was not protected from neglect on a specified date when the staff failed to provide resident #007 with two meals and no action was taken to ensure that the resident received their daily minimum food and fluid requirements.

ii. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for two incidents that occurred on two specified dates. The report alleged that some residents were not served a meal on both days due to staffing shortages.

The home's investigative interview notes were reviewed during this inspection and identified the following information:

RPN #107 identified that six residents were in bed at the meal on a specified date due to staffing shortages below the planned staffing complement, and confirmed that there was no food on the snack cart that day. RPN #107 stated that the residents in bed were offered food when the nourishment cart went around and all of the residents refused the food that was offered. The Executive Director #100 confirmed that trays had not been provided to residents who had not come to the dining room for the meal.

During interview with Inspector #107, PSW #162 identified that resident #035 was in bed during the meal on the first identified date and the resident would not have been able to agree or disagree to the choice of food offered at the snack pass. RPN #107 stated during interview with Inspector #107 that resident #035 was provided a small amount of additional nutritional supplement at the snack pass and was not provided with a meal. The Registered Dietitian assessed the resident as being at nutritional risk. The resident's plan of care directed staff to provide total assistance with meals and to offer the resident high energy high protein menu items at meals. The resident had significant weight loss and was well below their ideal body weight range.

In the interview notes for the second identified date, RPN #112 identified that nine residents were still in bed during the meal due to staffing issues and that residents were offered food from the snack cart. It was unclear if food was offered to residents at the snack pass on the identified date. PSW#162, who completed the snack service, stated

during interview with Inspector #107, that there was no food on the snack cart that day, however PSW #127, who was also working that day, stated that food was available on the snack cart.

During interview with Inspector #107, PSW #127, who was working in the identified home area on both identified dates, stated five residents (#047, #005, #048, #035, #012) were in bed at the meal on the first date, and that eight residents (#012, #035, #049, #050, #048, #047, #005, #006) were in bed at the meal on the second date. PSW #127 stated that residents that had higher care requirements remained in bed as they did not have time to get the residents up. PSW #127 stated the usual practice when they were fully staffed to the usual staffing complement was to wake residents up and take them to the dining room. PSW #127 confirmed that staff did not wake the residents up or ask the residents if they wanted to go to the dining room on both days due to staffing shortages. PSW #127 stated that some of the residents routinely did not come for the meal (#005, #047, #048) but that other residents routinely came for meals and had not been awakened to offer the meal due to staffing shortages.

Not all residents were protected from neglect at meals on two specified dates, due to staffing shortages below the usual staffing complement. (107) [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas, were kept locked.

On a specified date, Inspector #107 observed that a door leading to the outside of the home was not locked. The area was used by residents, family, staff, and visitors, and the identified door did not exit into a secured outdoor courtyard.

An examination of the operation of this door confirmed that although there was a keypad on the wall to the left of the door, and there appeared to be a locking mechanism on the door, the door could be opened.

The Executive Director #100 was asked to attend the area and when they attempted to

open the door, it would not open. Minutes after this incident, the Executive Director returned and indicated to Inspector #129 that they checked the door on the way back to their office and the door opened. The Executive Director indicated that they thought the closing arm on the top of the door was preventing the door from closing completely and as a result the lock mechanism failed to engage and lock the door.

The Executive Director posted staff at this door to prevent residents from exiting the home while the door was being repaired.

The licensee failed to ensure that the door, leading from a common area to the outside of the home, was kept locked. [s. 9. (1) 1. i.]

2. The licensee failed to ensure that all doors leading to non-resident areas were kept closed and locked when they were not being supervised by staff.

On a specified date and time, in an identified home area, Inspector #107 found the key to a soiled utility room still in the lock and the door was unlocked. Cleaning supplies and chemicals were accessible in the unlocked room, including a bottle of general purpose disinfectant for which the label indicated the contents of the bottle were corrosive and poisonous. Staff were not in the area of the soiled utility room and a resident was wandering in the same hallway as the soiled utility room. Inspector #107 locked the door and brought the key to RPN #123. The RPN confirmed the soiled utility room door was required to be locked when staff were not supervising the area.

The next day, in the same home area, Inspector #107 found the door to the soiled utility room unlocked and unsupervised by staff. A resident was in the area wandering in the hallway. Housekeeping staff #153 told Inspector #107 that they were aware that the door to the soiled utility room was left open as they were going in and out and they were going to go back and lock it soon. The door was not consistently supervised by Housekeeping staff #153 and they did not have a sight line of the door while they were in and out of the room.

On the same date, at a different time, in the same home area, Inspector #107 found a key left in the door to the tub room. The door was not locked and the room was accessible to residents. The area was unsupervised by staff and Inspector #107 was able to access chemicals stored in the tub room, including a bottle of general purpose disinfectant with a label that identified the contents of the bottle to be corrosive and poisonous.

On the same date, at a different time, in the same home area, Inspector #107 found the soiled utility room to be unlocked and accessible to residents. The same chemicals were accessible to residents. Staff were not supervising the area. Inspector #107 informed RPN #112 who confirmed that the doors were to be locked when they were unsupervised by staff.

On the same date, at a different time, and in another home area, Inspector #107 found a key left in the lock of the tub room. The door was unlocked and accessible to residents. Inspector #107 was able to access additional chemicals, including a bottle of general purpose disinfectant with a label that identified the contents of the bottle to be corrosive and poisonous. Inspector #107 locked the door and replaced the key in the holder. Management was informed.

On the next day, the same soiled utility room in a specified home area was found unlocked and accessible to residents. The same chemicals as observed on the two previous days, were still present. PSW #158 came out of a resident's room and confirmed to Inspector #107 that the door was required to be locked when the room was unsupervised by staff and the PSW locked the door.

On a different date, Inspector #107 was able to enter a dining room servery through an unlocked door that went directly into the servery. The hot steam tables were turned on and hot to the touch, a hot water dispenser was accessible, and chemicals were accessible under the sink. Dietary Aide #154 confirmed that residents were not to have access to the servery and that the door had been left open. The Dietary Aide showed Inspector #107 that the lock on the door handle to the servery popped open when the handle was pulled to exit the servery. Dietary Aide #154 stated that it likely happened when staff exited the servery and forgot to push the lock button on the handle back in. Inspector #107 informed the Executive Director #100, who indicated that they had researched coded locks for the door but the cost was prohibitive.

The same non-compliance was identified previously, in inspection report #2019_539120_0021 dated July 11, 2019. Inspector #120 identified the same doors were found unlocked and unsupervised, specifically the door to the soiled linen room, and the door to the servery in the dining area. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 006 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 with O.Reg. 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents to not have access to must be,
i. kept closed and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres (cm).

On a specified date and time, Inspector #107 was able to enter a dining room through an unlocked main door to the dining room. The dining room was empty and unsupervised at the time Inspector #107 entered the dining room. Two large windows were opened fully with no restriction. The screens on the windows fit improperly with gaping at the bottom. Inspector #107 was easily able to remove the screen and the windows were large enough for easy access to an unrestricted area outside of the home.

The Director of Environmental Services (#109) confirmed that the windows were unrestricted and opened more than 15 cm and stated that an audit of all the windows in the home was completed in the summer but may have missed the windows in the dining room.

On the same date, the window in a family dining room was unrestricted. The window opened fully and was easily accessible to the outside if the screen was removed.

On the same date, there was an open window in a second floor lounge that opened 17.5 cm. The screen was bent, was not secured, and was easily removed by Inspector #107. Inspector #107 would have been able to exit the home through the second story window.

On the same date the window opening in an identified room on the second floor measured 16.5 cm. The screen was not secured and the window was open.

On the same date, a window in the second floor dining room was unrestricted. Most of the windows had a chain restrictor, however, the identified window was missing the chain and opened fully (more than 15 cm).

The Director of Environmental Services (#109) toured the home with Inspector #107 and confirmed that the identified windows were unrestricted and/or opened more than 15 cm. [s. 16.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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 failed to ensure that the plan of care for resident #032 set out clear directions to staff and others who provided direct care to the resident.

The care plan for resident #032, indicated that the resident had food restrictions. The care plan directed staff to serve the resident specific foods and to discourage other

foods.

The dining room serving notes, that directed staff in the provision of menu items at the point of service, directed staff to provide certain foods to the resident, however, that direction contradicted what was in the resident's care plan.

During interview, the resident reported to Inspectors #107 and #156 that they were not able to consume certain foods that the serving list directed staff to provide to the resident.

Discussion with the Food Service Supervisor #156 and Executive Director #100, confirmed that the plan of care did not set out clear directions to staff and others who provided direct care to resident #032 in relation to their food restrictions. [s. 6. (1) (c)]

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

This is additional evidence to support non-compliance with existing compliance order 'not past-due', from July 2019 Complaint Inspection 2019_695156_0002, CO #001 with a compliance due date of October 7, 2019.

A. The licensee failed to ensure that resident #015's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #015's clinical record indicated that the resident was unable to consent to being assessed or to treatment due to their cognitive status. At the time of this inspection, the resident was observed to be unable to respond to simple greetings. Resident #015's family member was identified as being the Substitute Decision Maker (SDM) and staff contacted this family member related to care needs and consent related to assessment and treatment issues.

Resident #015's SDM was not given the opportunity to participate in the development and implementation of the resident's plan of care when the resident was assessed by contracted staff #140 and received treatment, without the SDM's consent.

A medication incident report, and a clinical note recorded by contracted staff #141, indicated that on a specified date, resident #015 was mistaken for a co-resident. Contracted staff #140 assessed the resident and determined that resident #015 would benefit from a treatment. Clinical records made by contracted staff #140 indicated that on the above noted date, resident #015 received the treatment.

A clinical note, made by contracted staff #141, indicated that following the treatment, the resident's SDM was contacted and the above noted incident was explained to them.

Resident #015's SDM was not given the opportunity to participate in the development and implementation of the resident's plan of care when they were not consulted and had not provided their consent for resident #015 to be assessed or to receive treatment. (129)

B. The licensee failed to ensure that resident #032 was given an opportunity to participate fully in the development and implementation of their nutritional plan of care.

The plan of care for resident #032 indicated that the resident had food restrictionss and directed staff to serve foods from an individualized menu.

On a specified date, the Registered Dietitian #157 was informed by Inspector #107 that the individualized menu for resident #032, that was available to staff preparing and portioning meals, had not been revised when the new menu was introduced, two months prior. The RD stated they would develop an individualized menu to address the resident's dietary restrictions.

During interview with Inspector #107, Registered Dietitian #157 stated they had phoned the resident's Substitute Decision Maker (SDM) to obtain the resident's food preferences. The SDM was unable to provide much information so the RD directed staff to provide input into the resident's menu choices based on what they seemed to prefer. The RD confirmed that the resident was not involved in the development of their individualized menu.

During interview with Inspectors #107 and #156, resident #032 confirmed they had not been involved in the development of their individualized menu and stated they would like to be involved. The resident was aware of their dietary restrictions and able to identify some food preferences to the Inspectors.

The resident was not provided an opportunity to participate fully in the development and implementation of their nutritional plan of care. (107) [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to residents #012, #017, #001, and #038, as specified in the plan.

A. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan for resident #012.

A Critical Incident System report (CIS) was submitted to the Director regarding improper care for resident #012.

i. Resident #012 had a plan of care for continence that directed staff to check the resident for wetness. During interview with Inspector #506, Nursing Consultant #115 confirmed the resident's plan of care was not followed as the resident was not checked or provided continence care on a specified date.

ii. On the same date, resident #012 was found incontinent and it was confirmed that resident #012 was not wearing the correct continence product. Resident #012's plan of care indicated that resident #012 was to wear a specific product, however, resident #012 was not wearing the product that was indicated in their plan of care.

PSW #113 confirmed in an interview that they put the resident in a different product. The PSW confirmed that they did not follow the resident's plan of care in relation to the product used. The Nursing consultant #115 for the licensee confirmed to Inspector #506, that the staff did not follow resident #012's plan of care and provide the resident with the right incontinence product. (506)

B. The licensee failed to ensure that care set out in the plan of care for resident #017 was provided to the resident as specified in the plan related to the provision of a specific intervention related to responsive behaviours.

Interview with the DCS #101, and review of the clinical record for resident #017, identified that the resident received services from an external consultant beginning on a specified date. The resident was to receive full services, however, the DCS reported that the service was in fact, shared with resident #046 over a ten day period. The DCS confirmed that the care set out in the plan of care for the required service/intervention

was not provided to resident #017 as specified in the plan. (156)

C. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan related to falls prevention and management.

i. According to the clinical health record and a Critical Incident System (CIS) report, resident #001 sustained a fall on a specified date.

The plan of care for resident #001, at the time of the fall, directed staff to apply a specific falls prevention device.

During interview with Inspector #107, PSW #110 confirmed that they had not applied the device, as required in the resident's plan of care. Personal Support Worker #110 stated that their computerized access to the resident's plan of care was not working that day and that they relied on verbal information provided by PSW #106 related to the resident's care needs. PSW #110 confirmed they had not reviewed written information related to the care plan requirements for resident #001. PSW #106 and PSW #110 confirmed that the verbal information provided by PSW #106 had not included the requirement of the device. PSW #110 stated that they did not see the device when providing morning care and did not apply the device.

ii. Resident #001's plan of care also included a requirement for another fall prevention device/strategy. The Physiotherapist added the strategy to the resident's plan of care after the fall.

On a specified date, Inspector #107 observed resident #001 and the strategy was not in place. The resident had the strategy in place during previous observations by Inspector #107. Inspector #107 asked RPN #152 if there had been a change to the resident's plan of care or if the resident still required the strategy. The RPN checked the computer and confirmed that resident had not had a change to their plan of care and still required the strategy.

Inspector #107 spoke with PSW #151, who was providing care to the resident that day, and the PSW stated they were busy, had not worked on that particular unit for an extended time, and they did not see a handwritten note indicating the resident required the strategy. The PSW was not aware of the requirement in the resident's written plan of care. (107)

D. The licensee failed to ensure that the care set out in the plan of care for resident #038 was provided to the resident as specified in the plan related to nutrition and hydration.

The plan of care for resident #038 identified the resident required thickened consistency fluids. The home purchased milk, water, and juices in both honey and nectar thickened consistencies.

At an observed meal, resident #038 was provided water and juice that both appeared to be a consistency other than the consistency specified on the resident's plan of care.

Dietary Aide #138 poured glasses of the home's purchased thickened fluids for comparison to what was on the table for resident #038. Dietary Aide #138 confirmed with Inspector #107 that the resident received water and juice that were a different consistency than what was identified in the resident's plan of care.

Resident #038 did not receive thickened fluids at a consistency that was consistent with their plan of care at an observed meal. (107) [s. 6. (7)]

4. The licensee failed to ensure that the plan of care for resident #017 was reviewed and revised when the resident's care needs changed.

This is additional evidence to supports non-compliance with existing compliance order 'not past-due', from July 2019 Complaint Inspection 2019_695156_0002, CO #002 with a compliance due date of October 7, 2019.

The home submitted a CIS alleging abuse of resident #021 by resident #017. Following the incident, a strategy was put into place to manage the responsive behaviours of resident #017.

The written plan of care was not revised to include the strategy for resident #017 until a month and a half after the strategy was initiated. The plan of care was not reviewed and revised when the resident's care needs had changed in relation to the implementation of the behavioural strategy, as confirmed with Associate Director of Clinical Services (ADCS) #108. [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 with LTCHA, 2007, S.O. 2007, c.8, 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, (c) clear directions to staff and others who provide direct care to the resident, and
LTCHA, 2007, S.O. 2007, c.8, s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #9: 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 failed to ensure that the home, its furnishings, and equipment, were kept clean and sanitary.

A specified dining room was not kept clean. At approximately 1130 hours, on an identified date, Dietary Aide #126 reported that the housekeeping staff were to clean the floors between breakfast and lunch; however, confirmed that there was a lot of food debris on the floor and that the cleaning had not been completed. It was noted that the dining room was very dirty; the floors and walls near the steam table had dried food splashes, and dust and old food debris was near the edges and on top of the ledges near the pillars. The back door of the dining room had large cob webs near the top and the windows along the back wall had cob webs and visible dirt.

The Director of Clinical Services #101 confirmed that the dining room was not kept clean and sanitary. [s. 15. (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 with LTCHA, 2007, S.O. 2007, c.8, 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The Licensee 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.

The home's policy, "Abuse – Prevention, Elimination and Reporting Policy", indicated under the Protocol for investigating allegations of resident abuse by a resident: step 3,

that the staff member receiving the initial report shall ensure that all information was documented in both residents' progress notes in chronological order.

i. A Critical Incident System (CIS) report was submitted to the Director and identified an incident between resident #017 and resident#023 that resulted in an injury to resident #023. A review of the clinical record for resident #017 did not include documentation of the incident, as confirmed by Associate Director of Clinical Services (ADCS) #108.

ii. A CIS was submitted to the Director and identified an altercation between resident #017 and resident #022. A review of the clinical record for resident #017 did not include documentation of the incident as confirmed by ADCS #108.

The licensee failed to ensure that the abuse policy related to documentation in both residents' progress notes, was complied with. [s. 20. (1)]

2. The licensee failed to ensure there was a written policy to promote zero tolerance of abuse and neglect that, at a minimum, contained an explanation of the duty under section 24 to make mandatory reports.

In response to a request that the home provided the Licensee's written policy to promote zero tolerance of abuse and neglect of residents, Inspector #129 was provided with a 16 page document. The subject line of the first page identified the document as the "Abuse - Prevention, Elimination and Reporting Policy, with an effective date of September 2019.

i. The policy provided conflicting direction when the document directed, "The Ministry must be notified within 12 hours upon the home becoming aware of any other alleged, suspected or witnessed incidents of abuse or neglect of a resident". This statement was inconsistent with the requirement to immediately report abuse of a resident under the conditions identified in section 24 to make mandatory reports.

ii. The Licensee's policy did not contain the complete explanation of the reporting requirement identified in section 24 of the Long-Term Care Home Act, 2007, CHAPTER 8.

The reporting requirement, identified above, directed 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".

The licensee's policy noted above directed, "The Ministry of Health is to be notified immediately upon the home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident or that could potentially be detrimental to the resident's health or well-being".

The licensee's policy did not contain the caveats that the licensee was to immediately report a suspicion that abuse "may occur" and "that resulted in a risk of harm".

The licensee's policy contained conflicting and an incomplete explanation of the duty under section 24 to make mandatory reports to the Director. [s. 20. (2) (d)]

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 with LTCHA, 2007, S.O. 2007, c.8, s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (d) shall contain an explanation of the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #11: 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 failed to ensure that every incident of alleged, suspected or witnessed abuse or neglect of a resident by the licensee or staff, was immediately investigated.

A. A Critical Incident System report was submitted to the Ministry of Long-Term Care for an incident that alleged resident #004 did not receive a meal on a specified date.

During interview with Inspector #107, the Executive Director (ED) #100 and Associate Director of Clinical Services (ADCS) #107, were unable to provide Inspector #107 with investigative notes or the outcome of the investigation. The information provided to Inspector #107 included two, one page emails, between the ADCS #107 and the ED #100. One of the emails identified that a staff member was interviewed and included a summary of the interview, however, it did not indicate the date that the interview was conducted, who was present during the interview or what was asked of the staff member involved. The document indicated that the ADCS was to follow up with two more staff members present during the incident. No further documentation was available for review by Inspector #107. The ED #100 and ADCS #107 were unable to provide Inspector #107 with evidence that the other staff were interviewed or that the investigation was completed. (107)

B. The home submitted a CIS report alleging abuse of resident #021 by resident #017. The ED #100 confirmed that there were no investigative notes to show that an investigation into the incident had been completed.

The licensee failed to ensure that the alleged incident of abuse was immediately investigated. (156) [s. 23. (1) (a) (ii)]

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

A CIS report was submitted to the Director regarding improper care of resident #012.

Nursing Consultant #115 was notified the following morning by email, from the Associate Director of Clinical Services (ADCS) #108, of the improper care of resident #012 and they submitted a CIS to the Director and confirmed in the CIS that the staff would be completing a head to toe skin assessment to ensure there were no injuries to resident #012.

The CIS was amended by the Nursing Consultant that same day to say that there was no evidence of injury or skin break down noted; however, when Inspector #506 completed a review of the resident's clinical health record, it was noted that the head to toe skin assessment that was completed by RPN #112 that same day stated that the resident had two new areas of skin impairment.

An interview with RPN #112 confirmed that the two areas of skin impairment were new. Documentation in the progress notes had also stated that the skin impairment may have been caused by the improper care.

During an interview with Inspector #506, Nursing Consultant #115 could not confirm why they did not include in the CIS report that the resident had sustained new skin impairment and how the resident sustained the skin impairment as part of the investigation.

The licensee failed to ensure that the Director was notified of the results of every investigation. [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 with LTCHA, 2007, S.O. 2007, c.8, 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, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

A. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care and identified a concern about an improper transfer of resident #002 by PSW #117. The resident required the assistance of two staff for transferring and identified the resident was transferred using one staff.

During interview with Inspector #107, PSW #117 confirmed they transferred resident #002 by themselves. During interview with Inspector #107, PSW #116 stated they were aware at the time of the incident that PSW #117 had transferred resident #002 by themselves and that the resident required two staff members for assistance with transferring. PSW #116 confirmed they had not reported the improper transfer to management.

The incident occurred on a specified date, however, was not reported to the Director until three days later. During interview with Inspector #107, Executive Director #100 stated that they did not become aware of the incident until three days later.

B. A Critical Incident System Report (CIS) was submitted to the Ministry of Long-Term Care for an incident that alleged that staff did not apply resident #001's falls prevention device and the resident sustained a fall.

Resident #001 had a plan of care that required the use of a falls prevention device. The required device had not been applied at the time of the incident.

During interview with Inspector #107, Executive Director (ED) #100 stated that they did not report the incident immediately as they were unclear that it was reportable. It was not immediately identified that the resident required the falls prevention device and that it had not been applied at the time of the incident.

C. A Critical Incident System (CIS) report was submitted to the Director reporting an incident of improper and incompetent care of resident #012 that took place on a specified date. A review of the licensee's clinical records, investigation notes, and the CIS report, confirmed that the Executive Director (ED) was made aware of the incident by the registered staff on duty. The ED confirmed that they did not direct the registered staff to report the incident to the MOLTC Director at that time, nor did they notify the Director themselves. The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director. (506) [s. 24. (1) 1.]

2. The licensee failed to ensure that a 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, immediately reported the suspicion and the information upon which it was based to the Director.

A. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for suspected neglect of a resident where a meal was not provided to resident #004. The Critical Incident System report was not submitted immediately. During interview with Inspector #107, the Executive Director (ED) #100 was unable to determine why there was a delay in reporting the incident to the Director. (107)

B. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for an incident that alleged resident #007 was not provided two meals on a specified date. Inspector #107 attempted to interview the resident, however, the resident was not interviewable.

Investigative interview notes, completed by ED #100 and the Director of Clinical Services (DCS) #101, identified that both PSW #159 and PSW #161 were aware that resident #007 was not offered two meals in one day and the incident was not reported to management prior to leaving the home at the end of either staff member's shift.

During interview with Inspector #107, the ED #100 confirmed that they had been working on the specified date, and had not been informed of the incident on the day that it occurred and did not become aware of the incident until six days later. (107)

C. Staff in the home did not immediately inform the Director after they received information related to resident #013 that indicated the resident could have been abused by a co-resident and/or that the ongoing behavior of the co-resident could have resulted in injury to resident #013. A Critical Incident System (CIS) report was submitted to the Director in excess of 10 hours later.

During a discussion with the Executive Director (ED) #100, they verified that the above noted information had been provided to the Acting Director of Clinical Services (A-DCS) and they had not notified the Director immediately after they received the information. The A-DCS had completed and submitted the CIS report over 10 hours later. The Executive Director (ED) indicated that according to the licensee's policy, only the ED and the Director of Clinical Services (DCS) could submit a CIS report and this late reporting

was, in part, related to a staffing issue.

Staff in the home did not notify the Director immediately when they became aware that there were three reported incidents of suspected physical and/or emotional abuse of resident #013. (129) [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 with LTCHA, 2007, S.O. 2007, c.8, s. 24 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A. The licensee failed to ensure that any actions taken with respect to resident #003

under the skin and wound care program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

Documentation by RPN #120 in the progress notes of resident #003 on a specified date indicated an area of impaired skin integrity was resolved. Documentation in the progress notes on the same day by RPN #112, indicated that the resident had an area of skin impairment and staff were to continue to monitor the area. The Treatment Administration Record (TAR) monitoring of the area had been discontinued by RPN #120 on the same date.

The next day, PSW #118 improperly transferred resident #003 and the TAR directed staff to monitor the resident for skin impairment over a four day period. No skin impairment was identified to the specific areas during the monitoring period.

Five days after the incident, a weekly wound assessment and head to toe skin assessment, both completed by RPN #112, indicated an area of skin impairment. It was unclear from the documentation if the skin impairment was from the original area or was a new area related to the improper transferring of the resident.

During interview with Inspector #107, RPN #112 stated that the original assessment of the skin impairment, completed by RPN #120, indicated the area had resolved, however, RPN #112 was more familiar with the resident's skin impairment and the RPN went the same day to re-assess the area and identified it was still there. RPN #112 stated that they had confirmed with RPN #120 that RPN #120 had not assessed the correct area and had identified the area had resolved when it actually remained. Documentation by RPN #112 did not reflect the re-assessment of the area and it was unclear that the area of skin impairment remained.

The weekly wound assessment completed by RPN #112 identified the skin impairment was discovered on a certain date, however, skin assessments for that date identified a different location and type of impairment. During interview with RPN #112, they confirmed that the weekly wound assessment should have identified the skin impairment was discovered on a different date and was related to the original bruising. (107)

B. A CIS report was submitted to the Director for an incident of improper and incompetent care of resident #012.

In an interview with RPN #123 they confirmed that they did not document the incident or

their assessment of the resident in the clinical record of resident #012.

An interview with the Executive Director #100 confirmed that all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were not documented and should have been documented in resident #012's clinical health record. (506) [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with O.Reg. 79/10, 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including; identifying factors, based on an interdisciplinary assessment, and on information provided to the licensee or staff through observations, that could potentially trigger such altercations as well as the identification and implementation of interventions.

The licensee notified the Director through the Critical Incident System (CIS) when it was reported that there had been three incidents of responsive behaviours involving resident #014 towards resident #013.

During a discussion with resident #013 they confirmed both the responsive behaviour of resident #014 and the above noted incidents.

PSW #119, who acknowledged they were familiar with the residents on the same home area as resident #013, confirmed that resident #014 demonstrated responsive behaviours.

During a discussion with RPN #124, they reviewed resident #014's computerized clinical record and verified they were unable to locate a behavioural assessment related to the responsive behaviours demonstrated by resident #014. The plan of care was reviewed and RPN #124, as well as the clinical records, confirmed that a care plan focus related to the management of responsive behaviours had not been developed and there were no interventions identified to manage the identified behaviour.

Later on the same day noted above, a discussion was held with the Director of Clinical Services (DCS) #101 and Associate Director of Clinical Services (ADCS) #107, who was identified as the designated lead for the responsive behaviour management program.

During the discussion, both the DCS #101 and ADCS #107, reviewed clinical documentation and confirmed that an interdisciplinary assessment had not been completed before or after the reported the ongoing responsive behaviors and the altercations that had occurred as a result of resident #014's behaviours. At that time, they also verified that there was not a care plan focus, goal of care, or interventions developed or implemented for the management of the responsive behaviour demonstrated by resident #014.

Staff had not completed an interdisciplinary assessment and did not develop or implement interventions for the management of an identified responsive behaviour for the prevention of further altercations between resident #014 and co-residents. [s. 54.]

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 with O.Reg. 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance and food quality.

On a specified date, Cook #137 reported that the meal preparation for the 1700 hour dinner service was put into the oven at 1330 hours. The sweet and sour chicken and beef roulade, that were indicated on the menu, were in the oven, to be finished cooking

at 1415 hours. The rice was finished cooking at approximately 1430 hours, and these food items were hot held until meal service at 1700 hours. The Cook reported that after these items were cooked they went on break around 1530 hours, and would then go to a home area to set tables. It was reported that the only items left to prepare for meal service were the vegetables that would be put into the steamer when they returned from the home area.

The recipe for the sweet and sour chicken directed staff to cook the product for 18-20 minutes. The recipe also directed staff to take temperatures every two hours during hot holding. The Cook #137 stated that temperatures were not taken or recorded every two hours while food was hot holding. The Cook stated that temperatures were taken when the food was removed from the oven after cooking and then again when food was placed in each servery prior to service. Food temperatures during hot holding were not recorded.

The recipe for the beef roulade directed staff to refer to the box for the recipe, however, the box had been discarded and was unavailable for review by Inspector #107.

The staff was unsure why the meal preparation was completed so far in advance and felt that the timing of the preparation did not lend to food quality. The licensee failed to ensure that the foods were prepared and served using methods to preserve taste, nutritive value, appearance and food quality. (156) [s. 72. (3) (a)]

2. The licensee failed to ensure that the home had, and that the staff of the home complied with, (a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

A review of the Critical Incident System (CIS) that was submitted to the Director identified that there was an unplanned evacuation as a result of a fire in the steam table on a specified home area.

i. At 0820 hours, on the unit there was an unusual smell which appeared to smell like hot wires or hot rubber.
ii. At 0830 hours, there was smoke in the unit dining room and the licensee initiated an evacuation and pulled the fire station to prompt the fire alarm.
iii. At 0840 hours, the fire department arrived and continued to monitor the dining room with a device that sensed heat spots and then proceeded at 0845 hours, with the evacuation including residents from the second floor on another home area.

iv. At approximately 0900 hours, the fire department noticed a flame coming from inside the steam table well, that had been fueled by a rubber stopper drain that had been boiled dry.

During the inspection, Inspector #506 requested policies and procedures related to the steam table. The ESM #109 confirmed that they called the steam table company and that the vendor was unable to provide manufacturers instructions on the steam table as it was custom made and there were no policies which directed cleaning and looking after the steam table that they could find.

The DCS #101 was able to provide a policy from the corporate library titled "kitchen preventative maintenance" effective date August 2018, which stated that each of the appliances would be inspected and checked daily using the servery check list and a copy of the checklist would be passed to the Executive Director #100 for review at the monthly Continuous Quality Inspection meeting. The check list that was in place at the time of the fire did not include the steam tables.

An interview with the Director of Culinary Services #144 confirmed that they were not aware of any policies and procedures in place for the maintenance, prevention, or cleaning of the steam table and confirmed that staff were trained during orientation regarding the steam table.

Review of the orientation checklist with the ESM #109 confirmed that there was nothing on the checklist regarding the steam table on the orientation checklist. A review of the job routines that were in place at the time of the fire, and the routines that were currently in place for the dietary aide on the specified home area, did not include ensuring the steam table was filled with water on the day or evening shift.

Interview with the Executive Director #100 confirmed that corporate had a policy but the home did not implement the policies and procedures for the safe operation, cleaning and maintenance of the steam table. [s. 72. (7) (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 with O.Reg. 79/10, s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality, and

O.Reg. 79/10, s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee included the following material in writing with respect to alleged, suspected, or witnessed incidents of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

A description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident, and the names of all residents involved in the incident.

A. A Critical Incident System (CIS) report that was submitted to the Ministry of Long-Term Care did not include the names of staff members or other persons who were present at the incident.

The Director of Clinical Services (DCS) (#101) confirmed that the critical incident report submitted to the Director did not include the names of the staff who were involved in the incident.

B. A Critical Incident System (CIS) report that was submitted to the Ministry of Long-Term Care identified only two residents that were involved in the incident. The home's investigation notes all identified additional residents who may also have been affected by the incident, however, these resident names were not included in the CIS report submitted to the Ministry of Long-Term Care.

During interview with Inspector #107, Executive Director #100 confirmed that there were additional residents that were identified in their investigation, however, only two residents were included on the CIS report submitted to the Director. The CIS report to the Director had not been updated to include the names of the additional residents and had also not been updated with the outcome of the investigation. [s. 104. (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 with O.Reg. 79/10, s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident, to be implemented voluntarily.

WN #17: 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 failed to ensure that drugs were stored in a medication cart that was secure and locked.

A. On a specified date and time, Inspector #107 observed medications sitting on top of a locked medication cart outside a dining room. The cart was unattended and unsupervised. A resident was sitting in the hallway beside the cart and residents were in the general area of the medication cart.

A yellow and black capsule pill, a bottle of Isotop tears, an inhaler, and a bottle of vitamins were sitting on-top of the medication cart. RPN #104 returned to the medication cart approximately five minutes later and identified the yellow and black capsule to be Nitrofuran, an antibiotic. The RPN stated that the capsule was to be discarded and they usually put the discarded medications in a container in the secured cart but they had forgotten. The RPN confirmed that the medications were supposed to be stored in the locked medication cart.

B. On a specified date and time, Inspector #107 observed a medication cart that was left unlocked. RPN #149 had their back to the cart while providing medication to a resident. Inspector #107 was able to open the drawer and take out a medication before RPN #149 noticed. When the RPN turned around they noticed Inspector #107 with the drawer open and medication in hand. The RPN told Inspector #107 that they had forgotten to lock the cart and the cart should have been locked. [s. 129. (1) (a) (ii)]

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 with O.Reg. 7910, 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,
(ii) that is secure and locked, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review.

During a discussion with the Director of Clinical Services (DCS) #101 they confirmed that the quarterly review of medication incidents took place during the Professional Advisory Committee (PAC) meetings and they indicated that the first PAC meeting for 2019 was held on June 23, 2019. The DCS was unable to provide documentation that a quarterly review of the medication incidents that had occurred since the last review in 2018, had been undertaken prior to the meeting on June 23, 2019.

During the above noted discussion, the package of information from the PAC meeting held on the above noted date, was reviewed by the DCS as well as Inspector #129 and it was confirmed that the following reports/documents were included from the pharmacy provider:

1. A pharmacy report of the following auditing activities: drug utilization statistics, auditing activities completed related to two medication cart, auditing of physician orders on an identified home area, handing of cytotoxic drugs, the drug record book and narcotic/controlled drug handling, that had occurred in the first quarter of 2019.
2. A graph from the pharmacy provider that identified there were 14 medication incidents that occurred.
3. A report from the pharmacy provider that identified 12 specific types of medication incidents that had occurred.
4. A report from the pharmacy provider that identified pharmacy comments or action plans.

The DCS and the documented record of the June 23, 2019, PAC meeting minutes did not provide evidence that a review of all the medication incidents that occurred in the first quarter of 2019, was undertaken. [s. 135. (3) (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 with O.Reg. 79/10, s. 135 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policies, procedures, protocols or strategies, that the policies, procedures, protocols and strategies were complied with.

This is additional evidence to support non-compliance with existing compliance order 'not past-due', from Complaint Inspection 2019_695156_0002, CO #005 with a compliance due date of October 7, 2019.

A. In accordance with Ontario Regulation 79/10, s. 48 (1) 1 and in reference to O. Reg. 79/10, 49 (1) the licensee was required to have a falls prevention and management

program that provided a strategy for monitoring residents.

Specifically, staff did not comply with the licensee's policy, "Fall Prevention Program – Post Fall Management Policy Section 5.1", effective date May 2018, that directed Registered nursing staff to complete a Fall Risk Assessment and Pain Assessment after every fall as a strategy for monitoring the resident.

During interview with Inspector #107, RPN #104 confirmed that staff were to complete a pain assessment and a fall risk assessment, located under the Assessment tab in Point Click Care (PCC) after every fall.

The clinical health record for resident #001 identified the resident had pain after a fall, however, did not include a pain assessment under the "Assessment" tab in PCC for the time of the fall, as required in the home's policy.

The Associate Director of Clinical Services (ADCS) #107 confirmed that the strategy for monitoring the resident's pain through the Pain Assessment was not completed at the time of the fall as required by the Licensee's policy.

B. In accordance with O. Reg. 79/10, s. 53, the licensee was required to ensure the following were 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.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

While completing a CIS inspection related to the management of responsive behaviours demonstrated by resident #014, the DCS #101 was asked to provide the written approaches that directed staff in the management of responsive behaviours. In response, the DCS provided specific policies related to responsive behaviours.

Resident #014 was identified as a resident who demonstrated responsive behaviours which resulted in altercations with co-residents. The care and services provided to resident #014 were reviewed as part of this inspection.

1. A review of one of the Responsive Behaviour policies noted above, indicated the following:

i. Page one of the procedure included in the policy directed that the interdisciplinary team, with input from the resident and/or family member, where possible, would assess the responsive behaviour. The procedure went on to identify five items that were to be included in the assessment.

Staff did not comply with the directions contained in the above noted procedure when it was confirmed by the DCS #101, Associate Director of Clinical Services (ADCS) #107, RPN #124 and resident #014's clinical record, that the five items identified in the procedure where not part of the assessment of the resident.

ii. Page one of the above noted policy/procedure directed that the interdisciplinary team, with input from the resident and/or family where possible, would plan individualized interventions to meet the needs of the resident that are reflected in the responsive behaviour. Interventions that ensured the safety of the resident and others were also identified.

Staff did not comply with the directions contained in the above noted procedure when it was confirmed by the DCS#101, ADCS #107, and RPN #124, that resident #014's plan of care did not contain interventions to manage the responsive behaviour or to ensure the safety of the resident and others.

iii. Page two of the above noted policy/procedure directed that for any resident that exhibited a specific responsive behaviour, the resident was monitored at least hourly.

Staff did not comply with the above noted procedures when RPN #124 reviewed resident #014's clinical record and confirmed there was no evidence to support that the resident was being monitored at least every hour and ADCS #107 indicated they did not think resident #014 was a resident they were monitoring.

The licensee did not ensure that staff in the home complied with the written directions contained in the above noted licensee policy and procedure. (129)

C. In accordance with O. Reg. 79/10, s. 114(2) the licensee was required to have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, and destruction and disposal of all

drugs used in the home.

The licensee's Medication Management policy identified as Section M.6 in the Nursing Manual, with an effective date of November 2018, identified that the licensee would follow the identified pharmacy provider's written policies and procedures related to medication management.

The pharmacy provider policy "Medication Incident and Reporting and Management", identified as #lllA06A and copied by the DCS #101 from the Pharmacy Policy binder at the time of this inspection, directed, "The Director of Resident Care will log into the Risk Management Portal to review the report and documents their review and comments in the Risk Management Portal".

At the time of this inspection the DCS explained that the process used in the home to record all medication-related incidents was that the registered staff reported the incident to the Pharmacist by telephone. The Pharmacist or Registered Pharmacy staff member would document the incident by initiating a Risk Management report in the online risk management portal and the DCS would receive an alert that a medication risk management report had been made to the pharmacy. The DCS indicated that when an alert was received they would log into the pharmacy's Risk Management Portal to review the incident, identify the facility analysis and action plan related to the incident, and document their approval of the action plan.

The licensee did not comply with the directions identified in the above noted policy, when the following was identified:

1. A review of Medication Incident Report #8209 for an incident that occurred on a specified date, and involved resident #009 not receiving a medication as specified by the resident's Physician, indicated that the incident report had not been reviewed by the DCS and a facility analysis and action plan had not been documented.

2. A review of Medication Incident Report #7206, for an incident that occurred on a specified date, and involved resident #015 being mistaken for another resident, indicated that the incident report had not been reviewed by the DCS and a facility analysis and action plan had not been documented.

At the time of this inspection the DCS reviewed the above noted Medication Incident Reports and confirmed the there was no documentation to indicate that the reports were

reviewed or that there had been a facility analysis or action plan developed. (129) [s. 8. (1) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting residents #002 and #003.

This is additional evidence to support non-compliance with existing compliance order 'not past-due', from July 2019 Complaint Inspection 2019_695156_0002, CO #006 with a compliance due date of October 7, 2019.

A. According to a Critical Incident System (CIS) report , submitted to the Ministry of Long-Term Care, PSW #117 used an unsafe transfer while providing care to resident #002.

A "Safety in Ambulating, Lifting, and Transferring (SALT) Assessment" was completed for resident #002 and identified the resident required two staff for assistance with transfers or staff were to use a mechanical lift and that staff were to assess daily.

During interview with Inspector #107, PSW #116, who was working during the time of the incident, stated that staff used information located on the "SALT board" located at each resident's bedside to provide direction related to transferring and mobility needs of each resident. PSW #116 stated the SALT board included symbols on how staff were to transfer each resident and the level of assistance that was required.

During interview with Inspector #107, PSW #117 confirmed that they had received training and orientation related to the use of safe lift and transferring techniques and how to read the information on the SALT boards located in resident rooms. PSW #117 confirmed they transferred resident #002 by themselves while providing care on a specified date. PSW #117 confirmed they did not reference the SALT transfer

information board located beside the resident's bed or the resident's Kardex to confirm the care requirements of resident #002 prior to transferring the resident.

The staff did not use safe transferring techniques when transferring resident #002 during care.

B. The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting resident #003.

A Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care identified PSW #118 transferred resident #003 improperly.

PSW #118, who completed the transfer of resident #003, was unavailable for interview during this inspection. PSW #119, who stated they were in the room at the time of the incident, stated that PSW #118 did not transfer the resident using the techniques identified in the symbols on the SALT board at the resident's bedside. PSW #119 stated that PSW #118 transferred the resident using an improper/unsafe technique, causing a negative result for the resident.

PSW #118 did not use safe transferring techniques when assisting resident #003. [s. 36.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #012 was dressed appropriately, suitable to the time of day and in keeping with their preferences, in their own clean clothing and in appropriate clean footwear.

A CIS was submitted to the Director regarding improper care of resident #012 on a specified date.

Resident #012 was scheduled for a bath on a specified date. PSW #113 confirmed in an interview that they prepared resident #012 for their bath in the morning and left them in their pajamas wrapped in a flannel. They confirmed that they did not communicate with the bath nurse that day to follow up with them to see if the resident was going to have their bath. The resident was discovered by the evening staff still in their night clothes from the previous evening.

A review of the plan of care for resident #012 indicated that staff were to ensure clothing was clean and appropriate. The Nursing Consultant #115 for the licensee confirmed that the resident was not dressed appropriately when they were left in their night clothes from the evening before. [s. 40.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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 failed to ensure that there was a written record relating to each evaluation that included: date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

The DCS #101 provided a document they identified as the program evaluation for 2018 for responsive behaviour management. The Executive Director (ED) #100 confirmed that the document provided by the home was a working tool that was developed in 2018 and was continually being reviewed and revised. The ED confirmed that the written record of the evaluation provided did not include the date(s) the changes and improvements identified in the document were implemented. [s. 53. (3) (c)]

WN #23: 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 failed to ensure that staff did not perform their responsibilities before receiving specified training.

This is additional evidence to support non-compliance with existing compliance order 'not past-due', from Complaint Inspection 2019_695156_0002, CO #004 with a compliance due date of October 7, 2019.

Agency PSW #118 began work on a specified date. The employee's file had a record of completed Safe Ambulation Lifting and Transfer – SALT, completed and signed by the employee on the same date, however, staff were unable to provide Inspector #107 with documentation that supported that PSW #118 received training on the long-term care home's policy to minimize the restraining of residents, or infection prevention and control. The PSW was no longer working at the home. [s. 76. (2)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that following the annual evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect, the written record of the evaluation contained the dates that the evaluation was completed and the dates that changes and improvements were implemented.

The Director of Clinical Services (DCS) #101 provided a document they identified as the evaluation for 2018 to determine the effectiveness of the licensee's policy related to the prevention of abuse and neglect. The Executive Director #100 confirmed that the document provided by the home was a working tool that was developed in 2018 and was continually being reviewed and revised. The document provided as the written record of the evaluation did not include the date the evaluation was completed or the date (s) changes and improvements identified in the document were implemented. [s. 99. (e)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 217. The licensee shall ensure that there is a designated lead for the training and orientation program. O. Reg. 79/10, s. 217.

Findings/Faits saillants :

1. The licensee failed to ensure that there was a designated lead for the training and orientation program.

During a discussion with the Director of Clinical Services #101 they were asked for the name of the designated lead for the training and orientation program. They responded by saying that everyone sort of takes on different activities related to training and orientation and was unable to provide the name of the person designated to lead the training and orientation program in the home. [s. 217.]

Issued on this 2nd day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107), CAROL POLCZ (156), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2019_549107_0013
Log No. / No de registre :	012945-19, 014006-19, 014029-19, 014585-19, 015067-19, 016123-19, 016471-19, 016608-19, 017012-19, 017013-19, 017471-19, 017833-19, 018505-19, 018605-19, 018877-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 21, 2019
Licensee / Titulaire de permis :	Park Lane Terrace Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Park Lane Terrace 295 Grand River Street North, PARIS, ON, N3L-2N9
	Mike Schmidt

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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Name of Administrator / Nom de l’administratrice ou de l’administrateur :

To Park Lane Terrace Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

Specifically, the licensee must:
1. Ensure that the home environment of resident #010 and any other resident who demonstrates responsive behaviours, is evaluated to determine if a safe and secure environment has been provided. Action must be taken if any safety/security concerns are identified in order to ensure the resident remains safe within the home.
2. Ensure that outdoor spaces used by residents, remain secured at all times.

Grounds / Motifs :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

1. The licensee failed to ensure that the home provided a safe and secure environment for its residents.

The licensee notified the Director, through the Critical Incident System (CIS), that the home had not provided a safe and secure environment for resident #010. The home's investigative notes, including clinical information, and the above noted CIS report, indicated that resident #010 was repeatedly demonstrating responsive behaviours and a safe and secure environment had not been provided resulting in risks to the resident.

On a specified date, Inspector #129 observed resident #010 in an environment that was not safe and secured. This information was shared with the Director of Environmental Services (DES) #109 who indicated that they would ensure that a safe and secure environment was maintained.

A review of the findings from inspection #2019_539120_0021, completed on July 11, 2019, by Inspector #120, indicated that the licensee had failed to comply with this legislative section (LTCH Act, 2007, c. 8, s. 5), in-part due to the failure to provide a safe and secure environment. The above noted report indicated the Inspector directed the home to prepare a written plan of corrective action for achieving compliance and ensuring the home provided a safe and secure environment for its residents.
During a discussion with the DES, they acknowledged that they recalled the above noted inspection report. The DES was asked what plan the home had put in place to ensure the safety of the residents. The DES indicated that at the time of the previous inspection staff were instructed to ensure a secured environment was provided but a written plan of corrective action had not been created to ensure the environment remained safe and secured.

The licensee failed to ensure resident #010's environment was safe and secure when they became aware the resident demonstrated responsive behaviours.[s. 5.] (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 71 (3).

Specifically the licensee must:
1. Ensure that residents #007, #012, #035, #049, #050, #048, #047, #005, #006,and all other residents, are offered a minimum of three meals daily.
2. Develop a contingency plan that addresses staffing shortages below the planned staffing complement with strategies for getting residents to the dining room for meals.
3. Educate all registered nursing staff, and front line nursing and dietary staff, on the plan that was developed.
4. Develop and implement a process that consistently allows staff to identify when residents are not in the dining room with clear expectations around the provision of tray service to ensure that all residents are offered a breakfast meal.

5. Develop, implement, and document, an auditing process to ensure that all residents,
including those not able to be in the dining room, are offered three meals daily.

Grounds / Motifs :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

A. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for in incident that occurred in the home. The report alleged that

resident #007 was not offered or provided two meals on the same day. Inspector #107 attempted to interview the resident, however, the resident was not interviewable.

Investigative interview notes, completed by ED #100 and the Director of Clinical Services (DCS) #101, identified that PSW #159 and PSW #161 were aware that resident #007 was not offered two meals in one day, they took no action to provide food for the resident, and the incident was not reported to management prior to leaving the home at the end of either staff member's shift.

During interview with Inspector #107, Executive Director #100 confirmed that resident #007 was not offered two meals on a specified date.

B. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for two incidents that occurred in the home. The report alleged that some residents were not served a meal on two specified days due to staffing shortages.

The home's investigative interview notes were reviewed during this inspection and identified the following information:

RPN #107 identified that six residents were in bed at the meal on the first specified date, and confirmed that there was no food on the snack cart that day. RPN #107 stated that the residents in bed were offered food when the nourishment cart went around and all of the residents refused the food that was offered. The Executive Director #100 confirmed that trays had not been provided to residents who had not come to the dining room for the meal.

During interview with Inspector #107, PSW #162 identified that resident #035 was in bed during the meal on the first identified day and the resident would not have been able to agree or disagree to the choice of food offered during the snack pass. RPN #107 stated during interview with Inspector #107, that resident #035 was provided a small amount of additional nutritional supplement at the snack pass and was not provided with a meal.

In the interview notes for the second date, RPN #112 identified that nine residents were still in bed during the meal due to staffing issues and that

residents were offered food from the snack cart. It was unclear if food was available on the snack cart that day. PSW#162 who completed the snack service stated during interview with Inspector #107, that there was no food on the snack cart that day, however PSW #127, who was also working that day, stated that food was available on the snack cart.

During interview with Inspector #107, PSW #127, who was working in the identified home area on both day, stated five residents (#047, #005, #048, #035, #012) were in bed at the meal on the first date, and that eight residents (#012, #035, #049, #050, #048, #047, #005, #006) were in bed at the meal on the second date. PSW #127 stated that residents that required a higher level of care remained in bed as they did not have time to get the residents up. PSW #127 stated the usual practice when they were fully staffed to the usual staffing complement was to wake residents up and take them to the dining room for the meal. PSW #127 confirmed that staff did not wake the residents up or ask the residents if they wanted to go to the dining room on the two identified dates due to staffing shortages. PSW #127 stated that some of the residents routinely did not come for the meal but that other residents routinely came for meals and had not been awakened to offer the meal due to staffing shortages.

Not all residents were offered a meal on two identified dates due to staffing shortages below the usual staffing complement. [s. 71. (3) (a)] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 73. (2).

Specifically, the licensee must:
1. Ensure that staff do not place meals on the table for residents that require assistance with eating until someone is available to provide the assistance, including for residents #015, #031, #012, #036, #037, and #003, and any other resident.
2. Develop and implement a system that will identify which residents in the home require assistance with eating and who will provide the assistance with eating at meals, including assistance for the identified residents #012, #036, #037, and #003.
3. Re-develop and implement the dietary/nursing job routines around meal service to ensure that all staff are clear on the job responsibilities for each position and provide education for all staff that would be affected by the revised job duties.
4. Develop clear written directions for staff on the system that was developed and provide education for all staff involved in the system, and keep a record of the education that was provided.
5. Conduct frequent dining room audits to ensure that meals are not placed on tables prior to assistance being provided and that residents are receiving the required level of assistance with eating.
6. Document the outcome of each audit.
7. Revise the processes, as necessary, based on the results of the audits.

Grounds / Motifs :

1. The licensee failed to ensure that residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required by the resident.

Residents #012, #036, #037, and #003 were served a meal without having someone available to provide assistance with eating at three observed meal services.

The seating plan identified a PSW was assigned to provide assistance with eating at an identified table. The PSW "dining room assignments", that were posted in the dining room, outlined the duties of each PSW during each meal service. On that list, the same PSW was assigned to duties other than assisting residents with eating. The two documents were inconsistent.

During interview with PSW #129, the PSW confirmed they were the PSW assigned to that position, however, they confirmed they did not assist residents with eating at the identified table. The PSW stated they followed the assignment list which identified they were scheduled to serve meals and clear tables.

During interview with the Director of Clinical Services #101, the Food Services Supervisor #156, and Registered Dietitian #157, they were unaware of the discrepancy between the seating plan and dining room assignment sheets regarding whether staff were to assist residents at the identified table.

A. The plan of care for resident #003 identified the resident was at nutrition risk and required extensive assistance with eating, with some assistance needed at most meals. The resident had a significant weight loss over five months. The resident had a weight which was below their goal weight range and below their ideal body weight range, as identified in Point Click Care.

At an observed meal, resident #003 was seated at the identified table in the dining room. The resident's meal was placed on the table before any staff were at the table. The resident sat with their meal in-front of them not eating for almost the entire meal service. The resident had not eaten anything and staff briefly provided verbal encouragement to the resident which was unsuccessful. During interview with Inspector #107 after the meal about the resident's level of

assistance, PSW #125 stated that resident #003 just picked at their meals.

At another observed meal, resident #003 had a meal placed in-front of them and no assistance was provided to the resident until a staff member briefly sat down to assist the resident. The resident had not been eating the meal. Inspector #107 noted that the staff that had been sitting at the identified table was now assisting at a different table. Resident #003 was observed dipping their index finger into their meal to try to eat it. Staff had not returned to assist at the identified table other than to assist resident #012 after Inspector #107 had informed them that resident #012 had requested assistance. Resident #003 was sleeping at the table and also hadn't consumed their beverages.

At another observed meal, resident #003 was served a meal and was not assisted with the meal. The resident had not eaten. During interview with PSW #129 after the meal the PSW stated that resident #003 needed more assistance. PSW #129, who was assigned on the seating plan to assist at the identified table, confirmed they had not assisted at the table, however, thought PSW #160 provided assistance to the residents at the identified table. PSW #160 stated they were assisting at a different table and only provided very limited assistance to the residents at the identified table during the meal.

B. The plan of care for resident #036 identified the resident was at nutrition risk and required extensive assistance with eating. The plan of care indicated that they required assistance with most meals. The resident had a significant weight loss recorded over three months. The resident had a weight which fell below the resident's goal weight range and their ideal body weight range, as identified in Point Click Care.

At an observed meal, resident #036 was seated at the identified table in the dining room. Resident #036 had their meal placed on the table and staff did not come to assist the resident when the meal was placed on the table. Staff came to assist resident #036 briefly, however, left the table again and went to assist at a different table. The resident left the dining room without eating. When the resident was leaving the dining room, staff had not approached the resident to determine why they were leaving without eating. Inspector #107 asked the resident if they would like to try the alternative meal and the resident said yes. When Inspector #107 informed PSW #119 that the resident would like to try the

alternative meal, PSW #119 sat down and assisted the resident with eating. During interview with Inspector #107 after the meal about the resident's level of assistance, PSW #125 stated that resident #036 used to eat independently but required more assistance with eating after a decline in their health.

At another observed meal, resident #036 left the dining room without eating. During interview with PSW #129 at the end of the meal, the PSW stated that resident #036 required more assistance due to a decline in their condition. PSW #129, who was assigned on the seating plan to assist at the identified table, confirmed they had not assisted at the table, however, thought PSW #160 provided assistance to the residents at the identified table. PSW #160 stated they were assisting at a different table and only provided very limited assistance to the residents at the identified table during the meal.

On another date, Inspector #107 observed resident #036 trying to eat their meal using their index finger. There were no staff sitting at the table and staff did not identify that the resident required assistance.

C. The plan of care for resident #037 identified the resident was at nutrition risk and required extensive assistance with meal set up. The resident had some gradual weight decline and was below their ideal body weight range, as identified in Point Click Care.

At an observed meal, resident #037 was seated at the identified table in the dining room. Resident #037 had their meal placed on the table for an extended period and staff did not assist the resident. The resident was not eating their meal. Approximately 20 minutes later staff came briefly to assist the resident and the resident started eating. During interview with PSW #129, the PSW stated that resident #037 required cueing to initiate eating.

D. The plan of care for resident #012 identified the resident was at nutrition risk and required extensive assistance with eating with some assistance at all meals.

At an observed meal, resident #012 was seated at the identified table in the dining room. Inspector #107 observed resident #012 sitting with their meal in-front of them not eating. The resident had been sitting with their meal in-front of

them for approximately half an hour without assistance being offered. Resident #012 told Inspector they required assistance with their meal and were unable to cut up the food or pick it up and requested the assistance of Inspector #107. Staff were not seated at the table and had not identified the resident required assistance with their meal. The resident ate poorly at the meal.

At another observed meal, resident #012 was served their meal and assistance was not provided at that time to the resident. Almost an hour after the start of the meal, Inspector #107 noticed that resident #012 had not been eating. When asked by Inspector #107 why the resident was not eating the resident informed Inspector #107 that they required some assistance with eating. Inspector #107 informed PSW #136 who came and assisted the resident. (107)

2. During a meal observation by inspector #156, resident #015 was fully assisted with eating by PSW #136. Resident #031 had their food in front of them for 14 minutes until PSW #136 stopped feeding resident #015 and then started to feed resident #031. PSW #136 stopped and went back to resident #015 and assisted them with the rest of their meal, and then went back to resident #031 to assist them. Both residents sat for approximately fifteen minutes with their food in front of them and no assistance was provided.

The plan of care for resident #015 indicated that they were totally dependent on staff for the feeding; one staff was to physically assist the resident.

The plan of care for resident #031 indicated that they required extensive to total assistance of one staff for feeding.

The licensee failed to ensure that residents who required assistance with eating were not served a meal until someone was available to provide the assistance required by the resident. (156) [s. 73. (2) (b)] (156)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 004

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

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 must be compliant with O. Reg. 79/10, s.131(2).

The licensee shall prepare, submit, and implement a plan to ensure that resident #009, resident #004 and any other resident, is administered medications as specified by the prescriber.

The plan must include, but is not limited to, the following:
1. The development and implementation of a resident identification system that reliably allows for residents to be identified by all staff administering medications.

2. The development and implementation of an education/training program for all registered staff who administer medications in the home, including registered staff who work in the home pursuant to a contract between the licensee and an employment agency, related to safe medication administration practices. Documentation of the completion of this training is to be maintained by the home for presentation to an Inspector.

Please submit the written plan for achieving compliance for, 2019_549107_0013 to Michelle Warrener, LTC Homes Inspector, MOLTC, by email to SAO.generalemail@ontario.ca by December 6, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

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

A. Resident #009's Physician ordered the resident to receive specific medications during the day. The noted Physician's orders stipulated that the medication was to be held if the resident was not eating.

A review of clinical documentation made in the computerized clinical record confirmed resident #009 refused to eat a meal on a specified date, and the resident did not fully consume their next meal.

A review of the Medication Administration record indicated that RPN #102 administered the medication on the specified date when resident #009 had not eaten a meal and had not consumed their entire meal at the next meal service.

The licensee made a report to the Director, through the Critical Incident System (CIS), that indicated RPN #102 had administered the medication when the resident had not eaten an entire meal and when the resident had not fully consumed the next meal. The Critical Incident System (CIS) report, clinical notes, and other records maintained by the home, indicated that as a result of this incident, resident #009 experienced a negative outcome.

The licensee did not ensure that resident #009 was administered medications as specified by the prescriber when the resident was administered medications when they had not eaten an entire meal and had not fully consumed the next meal.

B. Resident #004's Physician ordered the resident to receive a specific medication twice daily.

A review of a Medication Incident Report maintained by the home, clinical notes made by RPN #139, and a written statement to the Executive Director made by RPN #139, indicated that resident #004 was administered medication that had been ordered for a co-resident. Information in the above noted records indicated that RPN #139 had not properly checked the medication label or the identity of resident #004 prior to administering six times resident #004's usual dose of medication. The Physician and Pharmacist were contacted and RPN #139 was directed to monitor the resident for negative effects throughout the shift, as well as to report the incident to staff working the oncoming shift. Clinical notes indicated resident #004's condition did not change and there was not a need for

additional actions related to the increased medication the resident received.

The licensee did not ensure that resident #004's medications were administered as specified by the prescriber when the resident was administered six times their ordered dose of medication.

The licensee failed to ensure that drugs were administered to resident #009 and resident #004 in accordance with the directions for use specified by the prescriber. [s. 131. (2)] (129)

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Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19. (1) of the LTCHA.

Specifically, the licensee must:
1. Ensure that residents #007, #012, #035, #049, #050, #048, #047, #005, and #006, and any other residents, are not neglected by the licensee or staff.
2. Develop and implement a process/procedure for staff to follow that allows residents to go to the dining room when there are staffing shortages below the usual staffing complement.
3. Develop and implement a process/procedure that will allow staff to: identify residents that do not go to the dining room; effectively communicate information about residents not going to the dining room between all staff involved; and identify a clear system on what steps are to be taken when residents do not go to the dining room; to ensure that residents are offered and assisted with a meal as required.
4. Develop and implement an auditing process to assess the effectiveness of the new processes/procedures and revise the system based on the results of the audit, as necessary. Documentation of each audit and evaluation will be required to be kept on file for review by Inspectors.

Grounds / Motifs :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

i. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for an incident that occurred on a specified date. The report alleged that resident #007 was not provided two meals on a specified date. Inspector #107 attempted to interview the resident, however, the resident was not

interviewable.

Investigative interview notes, completed by ED #100 and the Director of Clinical Services (DCS) #101, identified that both PSW #159 and PSW #161 were aware that resident #007 was not offered two meals, the staff took no action to offer the resident a meal, and the incident was not reported to management prior to leaving the home at the end of either staff member's shift.

During interview with Inspector #107, the ED #100 confirmed that they had been working on the date of the incident, and was not informed of the incident on the day that it occurred and did not become aware of the incident until several days later.

PSW #119 was assigned to provide care to resident #007 on the specified date. During interview with Inspector #107, PSW #119 stated that they had not observed the resident in the dining room but had documented that the resident ate and drank at the identified meals, based on what was reported to PSW#119 from colleagues. Documentation on the resident's food and fluid intake records reflected the resident consumed sufficient fluids that day, however, without the fluids documented at the two meals, the resident's fluid intake would have been significantly below their minimum daily fluid requirement, as indicated in the resident's plan of care.

During interview with Inspector #107, Executive Director #100 confirmed that resident #007 was not offered two meals on a specified date. The Executive Director confirmed the allegations of neglect were founded.

Resident #007 was not protected from neglect on a specified date when the staff failed to provide resident #007 with two meals and no action was taken to ensure that the resident received their daily minimum food and fluid requirements.

ii. A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care for two incidents that occurred on two specified dates. The report alleged that some residents were not served a meal on both days due to staffing shortages.

The home's investigative interview notes were reviewed during this inspection and identified the following information:

RPN #107 identified that six residents were in bed at the meal on a specified date due to staffing shortages below the planned staffing complement, and confirmed that there was no food on the snack cart that day. RPN #107 stated that the residents in bed were offered food when the nourishment cart went around and all of the residents refused the food that was offered. The Executive Director #100 confirmed that trays had not been provided to residents who had not come to the dining room for the meal.

During interview with Inspector #107, PSW #162 identified that resident #035 was in bed during the meal on the first identified date and the resident would not have been able to agree or disagree to the choice of food offered at the snack pass. RPN #107 stated during interview with Inspector #107 that resident #035 was provided a small amount of additional nutritional supplement at the snack pass and was not provided with a meal. The Registered Dietitian assessed the resident as being at nutritional risk. The resident's plan of care directed staff to provide total assistance with meals and to offer the resident high energy high protein menu items at meals. The resident had significant weight loss and was well below their ideal body weight range.

In the interview notes for the second identified date, RPN #112 identified that nine residents were still in bed during the meal due to staffing issues and that residents were offered food from the snack cart. It was unclear if food was offered to residents at the snack pass on the identified date. PSW#162, who completed the snack service, stated during interview with Inspector #107, that there was no food on the snack cart that day, however PSW #127, who was also working that day, stated that food was available on the snack cart.

During interview with Inspector #107, PSW #127, who was working in the identified home area on both identified dates, stated five residents (#047, #005, #048, #035, #012) were in bed at the meal on the first date, and that eight residents (#012, #035, #049, #050, #048, #047, #005, #006) were in bed at the meal on the second date. PSW #127 stated that residents that had higher care requirements remained in bed as they did not have time to get the residents up.

PSW #127 stated the usual practice when they were fully staffed to the usual staffing complement was to wake residents up and take them to the dining room. PSW #127 confirmed that staff did not wake the residents up or ask the residents if they wanted to go to the dining room on both days due to staffing shortages. PSW #127 stated that some of the residents routinely did not come for the meal (#005, #047, #048) but that other residents routinely came for meals and had not been awakened to offer the meal due to staffing shortages.

Not all residents were protected from neglect at meals on two specified dates, due to staffing shortages below the usual staffing complement. (107) [s. 19. (1)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 9. (1) 2.

Specifically, the licensee must:
1. Ensure that all doors leading to non-residential areas (utility rooms, serveries) are kept closed and locked when they are not being supervised by staff, and;
2. Develop and implement a strategy that ensures that staff are not leaving doors unlocked and unsupervised, and;
3. Develop and implement an auditing system to monitor staff compliance with ensuring that doors to non-resident areas remain closed and locked when unsupervised, and;
4. Revise the process based on the results of the audits. Develop and implement follow up actions or strategies where staff are not in compliance with keeping doors to non-resident areas closed and locked.

Grounds / Motifs :

1. The licensee failed to ensure that all doors leading to non-resident areas were kept closed and locked when they were not being supervised by staff.

On a specified date and time, in an identified home area, Inspector #107 found the key to a soiled utility room still in the lock and the door was unlocked. Cleaning supplies and chemicals were accessible in the unlocked room, including a bottle of general purpose disinfectant for which the label indicated the contents of the bottle were corrosive and poisonous. Staff were not in the area of the soiled utility room and a resident was wandering in the same hallway as the soiled utility room. Inspector #107 locked the door and brought the key to RPN #123. The RPN confirmed the soiled utility room door was required to be locked when staff were not supervising the area.

The next day, in the same home area, Inspector #107 found the door to the soiled utility room unlocked and unsupervised by staff. A resident was in the area wandering in the hallway. Housekeeping staff #153 told Inspector #107 that they were aware that the door to the soiled utility room was left open as they were going in and out and they were going to go back and lock it soon. The door was not consistently supervised by Housekeeping staff #153 and they did not have a sight line of the door while they were in and out of the room.

On the same date, at a different time, in the same home area, Inspector #107

found a key left in the door to the tub room. The door was not locked and the room was accessible to residents. The area was unsupervised by staff and Inspector #107 was able to access chemicals stored in the tub room, including a bottle of general purpose disinfectant with a label that identified the contents of the bottle to be corrosive and poisonous.

On the same date, at a different time, in the same home area, Inspector #107 found the soiled utility room to be unlocked and accessible to residents. The same chemicals were accessible to residents. Staff were not supervising the area. Inspector #107 informed RPN #112 who confirmed that the doors were to be locked when they were unsupervised by staff.

On the same date, at a different time, and in another home area, Inspector #107 found a key left in the lock of the tub room. The door was unlocked and accessible to residents. Inspector #107 was able to access additional chemicals, including a bottle of general purpose disinfectant with a label that identified the contents of the bottle to be corrosive and poisonous. Inspector #107 locked the door and replaced the key in the holder. Management was informed.

On the next day, the same soiled utility room in a specified home area was found unlocked and accessible to residents. The same chemicals as observed on the two previous days, were still present. PSW #158 came out of a resident's room and confirmed to Inspector #107 that the door was required to be locked when the room was unsupervised by staff and the PSW locked the door.

On a different date, Inspector #107 was able to enter a dining room servery through an unlocked door that went directly into the servery. The hot steam tables were turned on and hot to the touch, a hot water dispenser was accessible, and chemicals were accessible under the sink. Dietary Aide #154 confirmed that residents were not to have access to the servery and that the door had been left open. The Dietary Aide showed Inspector #107 that the lock on the door handle to the servery popped open when the handle was pulled to exit the servery. Dietary Aide #154 stated that it likely happened when staff exited the servery and forgot to push the lock button on the handle back in. Inspector #107 informed the Executive Director #100, who indicated that they had researched coded locks for the door but the cost was prohibitive.

The same non-compliance was identified previously, in inspection report #2019_539120_0021 dated July 11, 2019. Inspector #120 identified the same doors were found unlocked and unsupervised, specifically the door to the soiled linen room, and the door to the servery in the dining area. [s. 9. (1) 2.] (107)

This order must be complied with by /
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Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 16.

Specifically, the licensee must:
1. Ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters (cm) by completing an audit of all the windows in the home that open to the outdoors and are accessible to residents to ensure they do not open more than 15 cm, and;
2. Repair and/or replace any damaged window restricting devices, ensure they are suitable for the window type, and that they do not impede the ability for the window to be locked or closed, and;
3. Develop and follow a schedule to conduct a regular and routine audit of all resident accessible widows that open to the outdoors to verify: if there are any windows that have the window restricting devices removed or broken and replace/repair as necessary; if the windows are equipped with restrictors; and that they are effective in keeping the windows from opening more than 15cm.

Grounds / Motifs :

1. The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres (cm).

On a specified date and time, Inspector #107 was able to enter a dining room through an unlocked main door to the dining room. The dining room was empty and unsupervised at the time Inspector #107 entered the dining room. Two large windows were opened fully with no restriction. The screens on the

windows fit improperly with gaping at the bottom. Inspector #107 was easily able to remove the screen and the windows were large enough for easy access to an unrestricted area outside of the home.

The Director of Environmental Services (#109) confirmed that the windows were unrestricted and opened more than 15 cm and stated that an audit of all the windows in the home was completed in the summer but may have missed the windows in the dining room.

On the same date, the window in a family dining room was unrestricted. The window opened fully and was easily accessible to the outside if the screen was removed.

On the same date, there was an open window in a second floor lounge that opened 17.5 cm. The screen was bent, was not secured, and was easily removed by Inspector #107. Inspector #107 would have been able to exit the home through the second story window.

On the same date the window opening in an identified room on the second floor measured 16.5 cm. The screen was not secured and the window was open.

On the same date, a window in the second floor dining room was unrestricted. Most of the windows had a chain restrictor, however, the identified window was missing the chain and opened fully (more than 15 cm).

The Director of Environmental Services (#109) toured the home with Inspector #107 and confirmed that the identified windows were unrestricted and/or opened more than 15 cm. [s. 16.] (107)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

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