Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 12, 2018	2018_548592_0006	012623-17, 005766-18	Complaint

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Residence Saint-Louis
879 Chemin Parc Hiawatha OTTAWA ON K1C 2Z6

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

MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 16, 19, 20, 21, 22, 23 and April 03 and 04, 2018

**One complaint and one Critical Incident were inspected during the inspection.
Logs # 005766-18 and #012623-17 related to safe transfers, personal care and staff to resident physical and verbal abuse.
This inspection was also done concurrently with Inspection # 2018_548592_0005.
Finding under s. 6 (7) relates to Inspection # 2018_548592_0005.**

During the course of the inspection, the inspector(s) spoke with the home's Executive Director of Long Term Care (EDLTC), the Active Administrator at the time of the incidents, the Director of Care (DOC), the Assistant Director of Care (ADOC), one Physiotherapist, the Registered Dietitian (RD), two Food Services Managers (FSM), several Dietary Aids, several Registered Nurses (R.N.), several Registered Practical Nurses (R.P.N.), several Personal Support Workers (PSWs), and several residents.

During the course of the inspection, the inspector conducted a tour of the resident care areas, reviewed resident's health care records, relevant licensee policies and procedures, observed staff work routines, posted menus, several meal services, resident rooms, resident common areas, the delivery of resident care and services and staff to resident and resident to resident interactions.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation**

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other;
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Concerns were brought forward regarding resident #001 transferring and positioning technique.
(Log #016957-17)

A review of Resident #001 health care records was done by Inspector #592.
The current written plan of care dated on a specified date in 2017 indicated that resident #001 requires the assist of two staff for transfers and the use of a mechanical lift as needed when tired, especially on a specified period of the day and the use of and EZ turn disk for all other transfers due to a decreased in mobility.

Observations done by Inspector #592 in the resident's bedroom and noted that a pictogram related to the resident's transfer needs was located on the bed room wall. The pictogram identified that a ceiling lift with two person assist was to be used. It was also noted that there was a hand written note at the bottom of the pictogram, specifying two person assist on a specified period of the day.

On March 22, 2018, in an interview with PSW #103, the main caregiver of resident #001, the PSW indicated to the Inspector that several days ago, a request had been done for

the physiotherapist to come and assess resident #001 due to a decrease in mobility. PSW #103 indicated that previous to the physiotherapist assessment, resident #001 was being transferred with a ceiling lift with two staff assistance when in the room and with an EZ turn disk with two staff assistance when in the bathroom. However, due to decrease mobility, the resident's method of transfers were changed for the use of a ceiling lift at all times in the room and the use of a manual lift when using the bathroom. The PSW also showed to the Inspector, the pictogram in the resident’s room which indicated the use a ceiling lift with two person assist and the hand written note indicating two person assist on a specified period of the day. The PSW indicated that the pictogram was used as a guidance for the PSWs, however, the PSW indicated that the pictogram was not reflecting the actual method of transfer for resident #001 as the resident was to use the ceiling lift at all times in the room and a manual lift when using the bathroom as the resident would be at high risk of falling if the lift was not used. PSW #103 also indicated that a message was left several days ago for the staff in charge of changing the pictogram to have the pictogram changed for resident #001 as it was not the actual method of transfer used for the resident.

During a review of the resident’s progress notes and "Family Physiotherapy Reassessment" form, no documentation was found regarding changes in resident #001's transfer assistance needs from a specific time frame period up to the day that the inspection was conducted, from the physiotherapist.

On April 03, 2018, in an interview with Physiotherapist #107, the Physiotherapist (PT) indicated that the RAI MDS was completed every three months for each resident. If any changes occur in between these quarterly assessments, a referral would be done by the registered staff to have the physiotherapist reassess the resident. The PT further indicated that once the assessment of the resident is completed, documentation will be written on the "Family Physiotherapy Reassessment" form and also in the resident’s progress notes related to the reassessed resident mobility/transfer needs. The PT also indicated that the pictogram would be changed in the resident’s room and if the nursing staff is available, a verbal report would be provided if any changes were done in the method of transfer for a resident. The PT indicated that there were no instructions to complete any written plan of care for the changes in interventions and was unsure how the method of transfer was communicated between staff after their assessment was completed. The PT indicated that a referral was received lately, on a specified date for resident #001 and the resident #001's transfer needs were changed recently. The bedside pictogram was updated by the PT to reflect resident #001's current methods for transfer.

On April 03, 2018, in an interview with RPN #105, the RPN indicated to Inspector #592 that the physiotherapist was responsible to instruct the nursing staff of the new treatments/recommendations for residents once the assessment was completed. RPN #105 indicated that RN #110 was responsible to update the resident's plan of care following the physiotherapist reassessment and recommended transfer needs. RPN #105 indicated that the recommended changes were communicated to RN #110 last week, after resident #001 was assessed by the Physiotherapist. However RN #110 was on holidays and a memo was left for the RN to do the changes on the written plan of care of resident #001 once back from holidays. The RPN further indicated that the plan of care for resident #001 had not been yet updated.

On April 04, 2018, in an interview with RN #110, the RN indicated that they were in charge of the written plan of care on that specific unit. The RN further indicated that several PSW's had shared some concerns on a specified date, regarding the physical status of resident #001 and the need for the physiotherapist to reassess resident #001's transfer needs. RN #110 indicated that a referral was done on the next day after receiving the concerns from the staff members and that the plan of care was updated five days later after receiving the recommendations from the PT, upon the RN's return to work. The RN further indicated that the PSW's were instructed to use a lift whenever a transfer becomes difficult for the safety of the resident and their own safety. However, this information should have been communicated to the Registered staff to ensure that the mechanical lift should be used at all times to transfer the resident while waiting for the PT mobility/transfer reassessment.

On April 04, 2018, in an interview with the DOC, the DOC indicated that the home's expectations was that all the changes and recommendations done by the physiotherapist should be communicated to the registered staff who will then update the resident plan of care. The DOC further indicated that the staff should have collaborated with each other in order to be consistent with the care provided to resident #001.

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (this finding is a Compliance Order)

This finding is related to Log #005766-18.

Resident #001 was admitted to the home on a specified date with several medical diagnosis.

A review of resident #001's health care record was completed by Inspector #592 which indicated that according to the current plan of care under Bladder function, that the staff needed to advise the RN of any strong smelling or concentrated urine has the resident has a history of frequent urinary tract infections.

On March 22, 2018, in an interview with RPN #100, the RPN indicated to Inspector #592 that resident #001 was identified with alteration in bladder function due to recurrent urinary tract infections mostly caused by not drinking enough fluids, therefore the staff were to stimulate the resident to increase the intake of fluids. RPN #100 further indicated that the staff needs to monitor resident #001 for any signs of confusion, weakness or any discomfort when voiding which would indicate a possible sign of a bladder infection. The RPN also indicated that to prevent the recurrence of a bladder infection, the PSW's were doing a specific treatment each time they were providing continence care to the resident. RPN #100 showed to the Inspector the Medication Administration Records (MARS) for resident #001 which indicated a specific treatment when providing continence care to the resident. Documentation showed that the treatment was provided on that same day. RPN #100 indicated that the PSW would come and ask for the specific treatment whenever they were ready to provide continence care to resident #001 and then the PSWs would let the RPN know once it was completed in order for the RPN to sign the MARS.

A review of resident #001's "Physician's Order Review" was completed by Inspector #592 which indicated to provide the treatment to resident #001 every shift. It was noted that the order was initially started on a specified date in 2017.

On March 22, 2018, in an interview with PSW #103, full time staff assigned to resident #001, the PSW indicated to the Inspector that continence care had been provided to the resident that morning. PSW #103 further indicated that the resident needed to be stimulated in order to drink more fluids to prevent the recurrence of urinary tract infection and that if any redness was observed to the perineal area, a barrier cream would be applied. The PSW indicated that there was no redness at this present time, therefore no need for barrier cream. When the Inspector inquired about the specific treatment used for the resident when providing continence care, the PSW indicated not being aware of any instructions or other specific treatment and that usually it would be the nurses that would provide that specific type of treatment. PSW #103 indicated that the resident was regularly assigned on a rotation basis under their care and that no specific instructions were ever received to provide resident #001 with that specific treatment when providing continence care. PSW #103 also indicated that the only time the nurse would be notified when providing continence care, is if the resident would present with a skin problem.

On March 22, 2018, in an interview with PSW #101, full time staff assigned to resident #001 regularly, PSW indicated that resident #001 was known to have recurrent bladder infections, therefore the staff needed to report immediately to the RPN if there were signs and symptoms of an infection in order for them to assess. PSW #101 further indicated that other than barrier cream, there was no other treatment provided when providing continence care to the resident, unless there was some changes done to the resident #001's continence care as PSW #101 was not assigned to resident #001 on that day. PSW #101 indicated that continence care was to be provided by two staff members and no other specific treatments were used for resident #001. PSW #101 further indicated that the only time the staff will ask the nurse to come while providing continence care is if the resident has a redness or a skin problem.

On March 23, 2018, in an interview with RPN #105, the RPN indicated that resident #001 was having recurrent urinary tract infections and was to be provided with a specific treatment when continence care was being provided. RPN #105 further indicated that the PSW would notify the RPN when they were providing continence care to the resident in order for the RPN to do the treatment.

On March 23, 2018, in an interview with PSW #103, the PSW indicated to the Inspector that resident #001 had received continence care that morning and the PSW was not aware that the nurse should come in order to perform a treatment. PSW #103 indicated that the resident has been assigned on a regular basis and was not aware that a nurse should be notified when providing continence care.

On March 23, 2018, in an interview with RPN #100 who had worked in the morning of March 22, 2018, the RPN indicated that PSW #116 was the one who performed the treatment to resident #001.
During an interview that was conducted on March 22, 2018, PSW #116 indicated not being assigned to resident #001 recently, therefore not fully aware of the current continence care for resident #001. PSW #116 was assigned on the same floor but not on the same unit.

On March 23, 2018, in an interview with the DOC, the DOC indicated that the RN and RPN were the staff responsible to provide the specific treatment to resident #001. The DOC further indicated that the RN and RPN should have provided the care as specified in the plan of care.

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (this finding is a Compliance Order)

A Critical Incident Report was submitted on a specified date, to the Director under the LTCHA, 2007 of alleged staff to resident physical abuse. The report was amended several days later, respective of the home's investigation. (Log #012623-17)

The incident was reported by resident #001 to the Administrator who was working at the home at that time, of a physical and verbal incident towards them by PSW #108 on a specified date. The resident described that the PSW was rough during the care, squeezing and hurting both arms when grabbed during the transfer and that the PSW was always rough when providing the care.

A review of Resident #001's health care records was done by Inspector #592.
The plan of care at the time of the incident indicated that resident #001 required two person transfer assistance and the use of a mechanical lift as needed when tired, especially on a specified period of the day. The written plan of care further indicated the use of an EZ turn disk for all other transfers due to a decreased in mobility.

A review of the Administrator's notes was completed, which indicated that PSW #108 was disciplined for not doing a two person transfer while in a rush which resulted in hurting resident #001.

On April 03, 2018, in an interview with resident #001, the resident indicated that pain was experienced to both arms when transferred by PSW #108 and that the transfer should have been done with the assistance of another PSW. Resident #001 further indicated that PSW #108 was in a rush and that the transfer was done very roughly and caused pain. Resident #001 further indicated that on the following day, the incident was reported directly to the Person in charge at that time who was responsible of the staff members.

In an interview with the Administrator who was working at the home at the time of the incident, the Administrator indicated that following the home's internal investigation, PSW #108 was found to not have used the proper technique when transferring resident #001 by transferring the resident alone when the resident was required two staff members. This resulted in resident #001 being hurt.

4. The licensee failed to ensure that the care set out in the plan of care is provided to the

resident as specified in the plan. This finding is related to Inspection #2018_548592_0005, Log #025592-17 done concurrently at the home. (this finding is a Compliance Order)

Resident #004 was admitted to the home on a specified date with several diagnosis including dementia.

A review of resident #004's health care record was completed by Inspector #592 which indicated that according to the current plan of care under nutrition status, resident #004 was to be provided assistance, with dietary interventions at meal times which included a specified diet, specified texture and specified fluids consistency. The plan of care also indicated that resident #004 was identified as being unable to make food choices due to altered cognitive functions. The plan of care indicated to not provide two specific food items to resident #004, however double portion of two other specified food items were to be provided to resident #004.

On March 19, 2018, Inspector #592 conducted a dining observation.
The Inspector observed resident #004 being assisted by PSW# 116 while sitting at the dining table. The resident was plated with three different food items including one of the item which was not allowed to be provided as per the resident's written plan of care.

When the Inspector inquired with PSW #116 if resident #004 was allowed to have the identified food item, the PSW told the Inspector that the plate was provided by DA #117 and did not know the resident's dietary needs.

DA #117 who was the staff assigned to the meal service indicated to the Inspector that the resident was allowed to have that specified food item for one specific meal time only. Inspector told the DA #117 that the kardex indicated to not provide this food item. DA #117 indicated that it was provided to the resident on a daily basis as per the family request.

A review of the resident #004 progress notes was done by the Inspector.
A progress note dated on a specified date, indicated that it was noted during an MOHTLC inspection that resident #004 was having difficulty swallowing the specified food item and that a follow-up was done by the Dietitian. The notes further indicated that it was confirmed by the staff members that the specified food item was too hard for the resident to eat and that the family member had notified the staff several times not to provide this specific food item to the resident.

During an interview with the RD, it was confirmed that resident #004 was not to be provided with this specific food item. The RD indicated that if there was meal specification for not providing a resident with a specific food item, the kardex would specify it, and at this current time, the identified food item was no to be provided at any time to resident #004.

5. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. This finding is related to Inspection #2018_548592_0005, Log #025592-17 done concurrently at the home. (this finding is a Compliance Order)

Resident #006 was admitted to the home on a specified date with several diagnosis including dementia.

A review of resident #006's health care record was completed by Inspector #592 which indicated that according to the current plan of care under nutrition status, resident #006 was to be provided assistance related to difficulty swallowing, with dietary interventions at meal times including a specified diet, specified texture, specified texture for an identified meal time and a specific fluid consistency. The plan of care also indicated that resident #006 was identified as being unable to make food choices due to altered cognitive functions.

On March 19 and 20, 2018, Inspector #592 conducted a dining observation.

On March 19, the Inspector observed RPN #105 giving instructions to PSW #116 to pour water from a container which was labelled with a specified fluid consistency which was not the one indicated in the resident's pan of care. The PSW pour the water and gave it to resident #006. Inspector #592 inquired with RPN #105 about the type of fluid consistency recommended for resident #006. The RPN was unsure and consulted with presence of the Inspector the kardex at the point of care for resident #006. RPN #105 indicated that resident #006 had received the wrong fluid consistency and instructed PSW #116 immediately to use the appropriate fluid consistency as per the care set up in the plan of care.

On March 20, the Inspector observed PSW #118 providing a cranberry juice to resident #006. When Inspector inquired about which type of fluid consistency was provided to resident #006, PSW pointed the container which was labelled with a specified fluid

consistency which was not the one indicated in the resident's plan of care. The PSW confirmed with the Inspector that it was the appropriate consistency fluids. Inspector #592 showed the kardex at the point of care of resident #006 which indicated to provide a different specified fluid consistency. The PSW indicated that there was no difference between the two fluid consistencies and that usually the fluid texture identified in the kardex was not available, therefore was using a different fluid consistency for resident #006. PSW #118 removed the wrong fluid consistency from the resident and provided the resident with the appropriate fluid consistency.

As such, resident #004 and resident #006's care set out as related to nutritional care was not provided as specified in their plan of care.

The severity of these issues was a level 3 as there was Actual harm to resident #001 and risk of harm to resident #004 and #006. The scope was a level 2 as it related to three of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

Voluntary Plan of Correction made under s. 6(7) of the Regulations, November 30, 2015
Written Notification made under s. 6(7) of the Regulations, June 28, 2016
Voluntary Plan of Correction made under s. 6(7) of the Regulations, February 17, 2017
Voluntary Plan of Correction made under s. 6(7) of the Regulations, April 13, 2017
Voluntary Plan of Correction made under s. 6(7) of the Regulations, October 03, 2017

Additional Required Actions:

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

Issued on this 12th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2018_548592_0006
Log No. / No de registre :	012623-17, 005766-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 12, 2018
Licensee / Titulaire de permis :	Bruyère Continuing Care Inc. 43 Bruyère Street, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	Residence Saint-Louis 879 Chemin Parc Hiawatha, OTTAWA, ON, K1C-2Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Melissa Donskov

To Bruyère Continuing Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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. 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).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically the licensee must:

1. Ensure resident #001's transfers and continence care related to the prevention of urine infection are provided to the resident in accordance with the plan of care.
2. Ensure resident #004 and #006 are provided with their prescribed diet as specified in the plan of care.
4. Ensure weekly audits are done for 4 consecutive weeks related to resident #001 and any other residents transfer and continence care as well as related to resident #004, #006 and any other residents prescribed diets.
5. Implement timely corrective actions as the issues are identified during the audit process to ensure that the care provided to the residents is in accordance with their plan of care.
6. A record of these audits must be documented and kept in the home.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (this finding is a Compliance Order)

This finding is related to Log #005766-18.

Resident #001 was admitted to the home on a specified date with several medical diagnosis.
A review of resident #001's health care record was completed by Inspector #592

which indicated that according to the current plan of care under Bladder function, that the staff needed to advise the RN of any strong smelling or concentrated urine has the resident has a history of frequent urinary tract infections.

On March 22, 2018, in an interview with RPN #100, the RPN indicated to Inspector #592 that resident #001 was identified with alteration in bladder function due to recurrent urinary tract infections mostly caused by not drinking enough fluids, therefore the staff were to stimulate the resident to increase the intake of fluids. RPN #100 further indicated that the staff needs to monitor resident #001 for any signs of confusion, weakness or any discomfort when voiding which would indicate a possible sign of a bladder infection. The RPN also indicated that to prevent the recurrence of a bladder infection, the PSW's were doing a specific treatment each time they were providing continence care to the resident. RPN #100 showed to the Inspector the Medication Administration Records (MARS) for resident #001 which indicated a specific treatment when providing continence care to the resident. Documentation showed that the treatment was provided on that same day. RPN #100 indicated that the PSW would come and ask for the specific treatment whenever they were ready to provide continence care to resident #001 and then the PSWs would let the RPN know once it was completed in order for the RPN to sign the MARS.

A review of resident #001's "Physician's Order Review" was completed by Inspector #592 which indicated to provide the treatment to resident #001 every shift. It was noted that the order was initially started on a specified date in 2017.

On March 22, 2018, in an interview with PSW #103, full time staff assigned to resident #001, the PSW indicated to the Inspector that continence care had been provided to the resident that morning. PSW #103 further indicated that the resident needed to be stimulated in order to drink more fluids to prevent the recurrence of urinary tract infection and that if any redness was observed to the perineal area, a barrier cream would be applied. The PSW indicated that there was no redness at this present time, therefore no need for barrier cream. When the Inspector inquired about the specific treatment used for the resident when providing continence care, the PSW indicated not being aware of any instructions or other specific treatment and that usually it would be the nurses that would provide that specific type of treatment. PSW #103 indicated that the

resident was regularly assigned on a rotation basis under their care and that no specific instructions were ever received to provide resident #001 with that specific treatment when providing continence care. PSW #103 also indicated that the only time the nurse would be notified when providing continence care, is if the resident would present with a skin problem.

On March 22, 2018, in an interview with PSW #101, full time staff assigned to resident #001 regularly, PSW indicated that resident #001 was known to have recurrent bladder infections, therefore the staff needed to report immediately to the RPN if there were signs and symptoms of an infection in order for them to assess. PSW #101 further indicated that other than barrier cream, there was no other treatment provided when providing continence care to the resident, unless there was some changes done to the resident #001's continence care as PSW #101 was not assigned to resident #001 on that day. PSW #101 indicated that continence care was to be provided by two staff members and no other specific treatments were used for resident #001. PSW #101 further indicated that the only time the staff will ask the nurse to come while providing continence care is if the resident has a redness or a skin problem.

On March 23, 2018, in an interview with RPN #105, the RPN indicated that resident #001 was having recurrent urinary tract infections and was to be provided with a specific treatment when continence care was being provided. RPN #105 further indicated that the PSW would notify the RPN when they were providing continence care to the resident in order for the RPN to do the treatment.

On March 23, 2018, in an interview with PSW #103, the PSW indicated to the Inspector that resident #001 had received continence care that morning and the PSW was not aware that the nurse should come in order to perform a treatment. PSW #103 indicated that the resident has been assigned on a regular basis and was not aware that a nurse should be notified when providing continence care.

On March 23, 2018, in an interview with RPN #100 who had worked in the morning of March 22, 2018, the RPN indicated that PSW #116 was the one who performed the treatment to resident #001.
During an interview that was conducted on March 22, 2018, PSW #116 indicated not being assigned to resident #001 recently, therefore not fully aware of the current continence care for resident #001. PSW #116 was assigned on the same floor but not on the same unit.

On March 23, 2018, in an interview with the DOC, the DOC indicated that the RN and RPN were the staff responsible to provide the specific treatment to resident #001. The DOC further indicated that the RN and RPN should have provided the care as specified in the plan of care.

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (this finding is a Compliance Order)

A Critical Incident Report was submitted on a specified date, to the Director under the LTCHA, 2007 of alleged staff to resident physical abuse. The report was amended several days later, respective of the home's investigation. (Log #012623-17)

The incident was reported by resident #001 to the Administrator who was working at the home at that time, of a physical and verbal incident towards them by PSW #108 on a specified date. The resident described that the PSW was rough during the care, squeezing and hurting both arms when grabbed during the transfer and that the PSW was always rough when providing the care.

A review of Resident #001's health care records was done by Inspector #592. The plan of care at the time of the incident indicated that resident #001 required two person transfer assistance and the use of a mechanical lift as needed when tired, especially on a specified period of the day. The written plan of care further indicated the use of an EZ turn disk for all other transfers due to a decreased in mobility.

A review of the Administrator's notes was completed, which indicated that PSW #108 was disciplined for not doing a two person transfer while in a rush which resulted in hurting resident #001.

On April 03, 2018, in an interview with resident #001, the resident indicated that pain was experienced to both arms when transferred by PSW #108 and that the transfer should have been done with the assistance of another PSW. Resident #001 further indicated that PSW #108 was in a rush and that the transfer was done very roughly and caused pain. Resident #001 further indicated that on the following day, the incident was reported directly to the Person in charge at that time who was responsible of the staff members.

In an interview with the Administrator who was working at the home at the time of the incident, the Administrator indicated that following the home's internal investigation, PSW #108 was found to not have used the proper technique when transferring resident #001 by transferring the resident alone when the resident was required two staff members. This resulted in resident #001 being hurt.

3. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. This finding is related to Inspection #2018_548592_0005, Log #025592-17 done concurrently at the home. (this finding is a Compliance Order)

Resident #004 was admitted to the home on a specified date with several diagnosis including dementia.

A review of resident #004's health care record was completed by Inspector #592 which indicated that according to the current plan of care under nutrition status, resident #004 was to be provided assistance, with dietary interventions at meal times which included a specified diet, specified texture and specified fluids consistency. The plan of care also indicated that resident #004 was identified as being unable to make food choices due to altered cognitive functions. The plan of care indicated to not provide two specific food items to resident #004, however double portion of two other specified food items were to be provided to resident #004.

On March 19, 2018, Inspector #592 conducted a dining observation.
The Inspector observed resident #004 being assisted by PSW# 116 while sitting at the dining table. The resident was plated with three different food items including one of the item which was not allowed to be provided as per the resident's written plan of care.

When the Inspector inquired with PSW #116 if resident #004 was allowed to have the identified food item, the PSW told the Inspector that the plate was provided by DA #117 and did not know the resident's dietary needs.

DA #117 who was the staff assigned to the meal service indicated to the Inspector that the resident was allowed to have that specified food item for one specific meal time only. Inspector told the DA #117 that the kardex indicated to not provide this food item. DA #117 indicated that it was provided to the resident

on a daily basis as per the family request.

A review of the resident #004 progress notes was done by the Inspector. A progress note dated on a specified date, indicated that it was noted during an MOHTLC inspection that resident #004 was having difficulty swallowing the specified food item and that a follow-up was done by the Dietitian. The notes further indicated that it was confirmed by the staff members that the specified food item was too hard for the resident to eat and that the family member had notified the staff several times not to provide this specific food item to the resident.

During an interview with the RD, it was confirmed that resident #004 was not to be provided with this specific food item. The RD indicated that if there was meal specification for not providing a resident with a specific food item, the kardex would specify it, and at this current time, the identified food item was no to be provided at any time to resident #004.

4. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. This finding is related to Inspection #2018_548592_0005, Log #025592-17 done concurrently at the home. (this finding is a Compliance Order)

Resident #006 was admitted to the home on a specified date with several diagnosis including dementia.

A review of resident #006's health care record was completed by Inspector #592 which indicated that according to the current plan of care under nutrition status, resident #006 was to be provided assistance related to difficulty swallowing, with dietary interventions at meal times including a specified diet, specified texture, specified texture for an identified meal time and a specific fluid consistency. The plan of care also indicated that resident #006 was identified as being unable to make food choices due to altered cognitive functions.

On March 19 and 20, 2018, Inspector #592 conducted a dining observation.

On March 19, the Inspector observed RPN #105 giving instructions to PSW #116 to pour water from a container which was labelled with a specified fluid consistency which was not the one indicated in the resident's pan of care. The PSW pour the water and gave it to resident #006. Inspector #592 inquired with

RPN #105 about the type of fluid consistency recommended for resident #006. The RPN was unsure and consulted with presence of the Inspector the kardex at the point of care for resident #006. RPN #105 indicated that resident #006 had received the wrong fluid consistency and instructed PSW #116 immediately to use the appropriate fluid consistency as per the care set up in the plan of care.

On March 20, the Inspector observed PSW #118 providing a cranberry juice to resident #006. When Inspector inquired about which type of fluid consistency was provided to resident #006, PSW pointed the container which was labelled with a specified fluid consistency which was not the one indicated in the resident's plan of care. The PSW confirmed with the Inspector that it was the appropriate consistency fluids. Inspector #592 showed the kardex at the point of care of resident #006 which indicated to provide a different specified fluid consistency. The PSW indicated that there was no difference between the two fluid consistencies and that usually the fluid texture identified in the kardex was not available, therefore was using a different fluid consistency for resident #006. PSW #118 removed the wrong fluid consistency from the resident and provided the resident with the appropriate fluid consistency.

As such, resident #004 and resident #006's care set out as related to nutritional care was not provided as specified in their plan of care.

The severity of these issues was a level 3 as there was Actual harm to resident #001 and risk of harm to resident #004 and #006. The scope was a level 2 as it related to three of four residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

Voluntary Plan of Correction made under s. 6(7) of the Regulations, November 30, 2015
Written Notification made under s. 6(7) of the Regulations, June 28, 2016
Voluntary Plan of Correction made under s. 6(7) of the Regulations, February 17, 2017
Voluntary Plan of Correction made under s. 6(7) of the Regulations, April 13, 2017
Voluntary Plan of Correction made under s. 6(7) of the Regulations, October 03, 2017
(592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2018

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

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

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

RENSEIGNEMENTS 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 12th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Melanie Sarrazin

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