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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Aug 14, 2014;	2014_179103_0015 (A1)	O-000278-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street, KINGSTON, ON, K7L-2Z3

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

RIDEAUCREST HOME
175 RIDEAU STREET, KINGSTON, ON, K7K-3H6

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

DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Rideaucrest Acting Administrator, Deb Skeaff requested an extension in the compliance dates for Orders #001 and #002 on August 1, 2014. The compliances dates have been extended to September 15, 2014.

Issued on this 14 day of August 2014 (A1)

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

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DARLENE MURPHY (103) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 4, 5, 9-13, 16-18, 20, 2014

The following logs were inspected during the Resident Quality Inspection:

Complaint intakes: : O-001097-13, O-001138-13, O-001047-13, and O-000527-14

Critical Incident intakes: O-000340-14, O-000313-14, and O-000272-14.

During the course of the inspection, the inspector(s) spoke with Residents, Resident Council President, Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Practitioner (NP), Best Practice champion for skin/wound care/continence care, Housekeeping staff, Dietary aides, Cooks, Dietary Supervisor, Nutritional supervisor/Dietitian, Physiotherapist and Physiotherapy aides, Restorative care RPN, Records and Staffing, Admissions Clerk, Acting Supervisor Administrative Services, Receiver, Supervisor of Resident Programs and Services, Life Enrichment Coordinator, Activity staff, Infection Control/Staff Development, Maintenance staff, RAI coordinator and back up, Assistant Directors of Care, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a full walking tour of all resident areas, observed resident dining and reviewed the current menu cycle and food temperature logs, observed medication administration and drug storage areas, observed resident care and resident activities, reviewed

infection control practices, reviewed relevant home policies, the home's continence and fall prevention programs, reviewed staffing schedules including Registered Dietitian hours, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 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:
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 has failed to comply with O. Regs 79/10 s. 9 (1) 2 whereby a door leading to a non residential area was not closed and locked when not being supervised by staff.

The floor to ceiling gated entrance into the kitchen on the lower level was observed by the inspector to be ajar by approximately one meter. From this vantage point, the inspector was able to see steam coming from a large vat within the second door that opens into the kitchen preparation area. The inspector entered directly into the kitchen and noted a large metal vat that contained boiling water. There were no staff in attendance of this area for the five minutes the inspector was present. This access to the kitchen is adjacent to the coffee shop and seating area that is used on a regular basis by staff, residents and family members. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 19 (1) (a) whereby residents were not protected from sexual abuse.

Sexual abuse is defined by the LTCHA, 2007 as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member."

On an identified date, S#134 observed Resident#3611 approaching a co-resident, proceeded to hug the resident and then placed his/her hand over the breast area of

Resident #11. Resident #11 has a diagnosis of Alzheimer's disease. S#134 stated she told resident #3611 to get away from the resident and assisted Resident #11 to the circle area in the home away from Resident #3611. S#134 stated she immediately reported the incident to the charge nurse on the unit as she viewed this as sexual abuse.

The charge nurse was unavailable for an interview due to an extended leave of absence, however, a copy of the incident report she completed was reviewed. The report indicated staff observed Resident #3611 "fondling" Resident #11's breast for ten seconds and the resident stopped immediately when requested by staff. The report indicated the incident was "inappropriate touching related to cognition change".

ADOC #106 was interviewed and stated she received notification of this incident on the following day by means of the twenty four hour report. She stated the twenty four hour report is generated each morning during the week days and reviewed by the management team during the daily morning meetings for any outstanding issues that may require follow up. The ADOC stated the twenty four hour report is not to be used for anything that requires the immediate attention of the management team. The home has an on-call manager who would be contacted for any urgent issues that occur outside of regular business hours.

The DOC also confirmed that the twenty four hour report is reviewed in the daily morning management meetings and also confirmed a seventy two hour report is generated every Monday so the management team can review any issues that arose over the weekend. The DOC further stated the charge nurses on the weekend are also expected to review the twenty four hour reports as a part of their charge nurse duties.

The Ministry of Health and Long Term Care Director and the police were notified of this incident by ADOC #106, some eleven hours after the incident had occurred.

Resident #12 and Resident #13 are both diagnosed with a cognitive impairments. Resident #12 is able to ambulatory and Resident #13 is a non ambulatory resident. During a review of Resident #12's progress notes the following incidents were recorded:

On an identified date, S#110 observed Resident #12 touching Resident #13's breasts. S#110 was interviewed and stated she recalled the incident. She advised the inspector it was a known behaviour and that both families were aware. She stated she

wasn't sure if she viewed the resident's actions as an alleged sexual abuse as she felt it's a grey area when dealing with two cognitively impaired residents. S#110 stated she did not believe the resident to be a sexual predator and that Resident #12 only seeks out this one resident. The staff member stated two cognitively impaired residents cannot give consent and that non-consensual touching is considered an alleged sexual abuse. She stated she did not report this incident to anyone, but did attach her progress note to the twenty four hour report. There was no evidence that resident consent was assessed at the time of the incident.

Upon review of Resident #12's and #13's progress notes and plans of care from November 2013 to the date of this incident, there was no indication this type of behaviour had previously been observed between these two residents and there was no indication the families of either resident were notified of the incident.

On another identified date, S#108 observed Resident #12 putting his/her hands up Resident #13's shirt. The staff member was interviewed and stated she reported the incident immediately to the RPN in charge and ensured the two residents were separated. S#108 stated she believed the actions were inappropriate and that it could be considered sexual abuse. She stated she knew it needed to be reported to the staff. This inspector attempted to contact RPN S#159 by telephone for an interview and a call back number was provided but not returned. The progress note in the resident's chart was reviewed and the note was included as a part of the twenty four hour report. There was no evidence that resident consent was assessed at the time of the incident. The twenty four hour report was reviewed and did contain documentation related to this incident. ADOC #106 could not explain why this incident was not reviewed during the morning management meeting. There was no indication either family members were notified of the incident.

On another identified date, RPN S#159 observed Resident #12 leaning over Resident #13 and rubbing the resident's breasts. A progress note was made and the note was included in the twenty four hour report. RPN S#159 completed a responsive incident report the same day and this report was revised the following day to indicate the Registered Nurse in charge and the family members were notified the day after the incident. The legislated time line for the notification of the substitute decision maker of this incident is within twelve hours of the incident.

According to the ADOC #106, RPN S#159 did not immediately notify management and that the twenty four hour report was how the team was advised of the allegation. CIATT (Centralized Intake Assessment and Triage Team) was contacted to determine

the time the home notified the Ministry of Health and Long Term Care. The SAC (Spill Action Centre) report indicated, a call was received by the after hours pager on the identified date of the incident at approximately 1637 hour. The caller indicated the alleged incident of sexual abuse occurred at 1400 hour despite the progress note being entered onto Resident #13's electronic progress notes at 1247 hours and the CIS report indicating 1250 hour as the time of the incident.

The Administrator asked to clarify the expectation of immediate reporting. The Administrator was advised the reporting is to be as soon as possible in the circumstances without delay. Any circumstances that delay the reporting should be reasonable and without any unexplained or unreasonable delay.

ADOC #106 was asked to describe the investigation into the allegations of sexual abuse between Residents #12 and #13. She stated the management team discussed the incident at the management morning meeting the day after the incident and determined the incident not to be sexual in nature. The team did not believe Resident #12 touched the co-resident's breasts. The ADOC further stated the staff stated Resident #12 often touches Resident #13's arms, face etc. but that the resident doesn't mean anything by it and the staff did not believe the resident's breasts had been touched. The ADOC stated staff reported Resident #12 seeks Resident #13 out and possibly believes this resident to be a spouse. The ADOC was asked why the staff member charted "the resident was leaning over the co-resident and rubbing his/her breasts" and the ADOC stated she didn't know why. Although RPN S#159 could not be interviewed, this inspector considered the documentation to be accurate. RPN S#159 documented Resident #12 touching Resident #13's breasts in the resident's progress notes as well as the internal incident report.

ADOC #106 and the Administrator were asked for the home's investigation notes and were unable to provide any written documentation or statements to support that an investigation had taken place.

On another identified date, RPN S#136 observed Resident #12 approaching Resident #13 and started to rub Resident #13's breasts. The staff member was interviewed and stated the staff immediately intervened to separate the residents when it happened. She recalled Resident #12 was unhappy about being taken away from Resident #13 and further stated this had been an ongoing problem between these two residents. RPN S#136 stated she did not report the incident to anyone else at that time, but did make a progress note and ensured the note would be included in the twenty four hour report because this goes to the management team. RPN S#136 was asked if she

viewed this incident as an alleged abuse and she stated yes. The staff member stated it was the reason Resident #13 had to be moved to another unit. RPN S#136 stated the resident didn't like being touched by Resident #12 and that Resident #13 would become nervous and upset. ADOC #106 could not explain why the information pertaining to this alleged sexual abuse had not been reviewed in the morning management meeting.

On another identified date, RPN S#129 observed Resident #12 touching Resident #13's breasts. The staff member stated the residents were immediately separated. RPN S#129 stated the incident was not reported to anyone else in the home or to the family members. A progress note was made and it was included in the twenty four hour summary. RPN S#129 stated they knew it wasn't right for a resident to touch another resident's breasts and stated he saw the incident as "cute". RPN S#129 did not feel it would be sexual abuse because both residents are cognitively impaired. There was no indication that resident consent was assessed at the time of the incident. ADOC #106 could not explain why the information pertaining to this alleged sexual abuse had not been reviewed in the morning management meeting.

Two of the identified incidents occurred during the weekend and, according to the DOC, the twenty four hour report should also have been reviewed by the Registered Nurse in charge for that weekend.

RPN S#109 was interviewed and stated Resident #12 had taken a fond liking to Resident #13 and believed the resident may have believed the co-resident to be a spouse. She stated Resident #12 sought out Resident #13 to the point that staff could not place the resident in the common area but had to locate the resident down one of the care wings because Resident #13 did not go down that wing. RPN S#109 stated she had conversations with Resident #13's family because she felt it was now unfair and isolating to the resident to remain on the same unit as Resident #12. Resident #13 was eventually relocated to another unit.

RPN S#109 was asked why the alleged sexual abuse between Resident #3611 and Resident #11 resulted in a more immediate action (referral to Geriatric psychiatry, medications reviewed and the resident was relocated to another area). She stated she believed there is not a consistent approach in how these types of behaviours are responded to or reported.

Resident #12's plan of care was reviewed from the date of the first incident involving Resident #13 and the date of this inspection. There was no indication the repeated

incidents had been reassessed.

Resident #13's plan of care was reviewed for the same time period and there were no interventions documented in regard to these repeated incidents. [s. 19. (1)]

2. The licensee has failed to comply with LTCHA, 2007 s. 19 (1) whereby residents are not protected from physical abuse.

Physical abuse between residents is defined by the LTCHA, 2007 as, "the use of physical force by a resident that causes physical injury to another resident."

During a review of Resident #12's progress, an entry was noted on an identified date. It stated Resident #24 approached Resident #12 and squeezed the resident's hand and it resulted in an injury. The ADOC #106 was interviewed, stated she remembered the incident, agreed it would be an alleged physical abuse and believed an incident report had already been sent to the ministry. The ADOC was unable to find documentation to support the immediate notification of the Director or any submission of a mandatory report. There was no evidence to support the families of Resident's #13 and #24 had been notified and there were no investigative notes related to this incident of abuse. [s. 19. (1)]

3. The licensee has failed to comply with LTCHA, s. 19 (1) whereby residents were not protected from financial abuse.

Financial abuse is defined by the LTCHA, 2007 as "any misappropriation or misuse of a resident's money or property."

On an identified date, S#113 was interviewed in regards to the financial status of Resident #15's account. According to S#113, the police were notified on an identified date to report suspicions of financial abuse.

On another identified date, S#113 reported to the inspector that the home had another alleged financial abuse involving Resident #3700 and provided the inspector with the date the police were notified of the need to investigate the allegations of financial abuse.

The Director of Care was interviewed and asked if the allegations of financial abuse had been reported to the Director for these two residents . She stated they had not yet been reported because nothing had been proven. The DOC was reminded that all

allegations of resident abuse require immediate reporting to the Director.

The Administrator and S#113 approached this inspector and advised they had reviewed their records and wished to report two more allegations of financial abuse that had not yet been reported to the Director involving Resident #25 and Resident #26. The documentation for the two accounts was provided to the inspector including the dates the police had been contacted for allegations of financial abuse.

All four allegations of financial abuse were not immediately reported to the Ministry of Health and Long Term Care Director.

The home's compliance history was reviewed for the past three years. In April 2014, the home was issued a Written notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007 s. 24 (failure to immediately report instances of alleged abuse to the Director) and a WN for abuse policy not complied with.

In November 2012, the home was issued a WN and a Compliance order (CO) for failing to notify the Substitute Decision Maker (SDM) of incidents of abuse, a WN for failing to immediately investigate allegations of abuse and a WN for failing to immediately report allegations of abuse to the police.

In October 2012, the home was issued a WN and a VPC for failing to immediately investigate allegations of abuse.

In August 2011, the home was issued a WN and a VPC for failing to immediately report allegations of abuse to the Director

The home has demonstrated an ongoing inability to sustain compliance related to abuse reporting and investigation. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 20 (1) whereby the home's written policy that promotes zero tolerance of abuse and neglect of residents was not complied with.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Policy Statement" states, "every person in the home has a mandatory and legal obligation to immediately report suspected or witnessed abuse. Under "Procedures", the policy further indicates to immediately report any suspected or witnessed abuse to the Administrator, Director of Care or their designate and the incident must be reported to the MOHLTC Director.

On four separate identified dates, S#113 contacted the police to report suspicions of financial abuse of Resident's #15, #25, #26 and #3700. The Administrator confirmed she was aware of these incidents. As of June 17, 2014, the four alleged financial abuses had not been reported to the Director.

On an identified date, a documented incident of physical abuse between Resident's #24 and #13 was noted in the progress notes. The ADOC #106 was interviewed, stated she remembered the incident, agreed it would be an alleged physical abuse and believed an incident report had already been sent to the ministry. The ADOC was unable to find documentation to support the immediate notification of the Director or any submission of a mandatory report.

On six identified dates, staff witnessed incidents between Resident's #12 and #13 that

constituted allegations of sexual abuse. None of the witnessed incidents were immediately reported. On an identified date, an alleged sexual abuse occurred between Resident's #3611 and #11. This alleged sexual abuse was reported to the Ministry of Health and Long Term Care's after hours pager on the day of the incident on or about 1637 hours when the incident reportedly occurred on or about 1250 hour.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Notification" states, the resident substitute decision maker is to be notified immediately of any alleged, suspected or witnessed incidents of abuse that result in physical injury or pain or distress and within twelve hours of becoming aware of any other alleged, suspected or witnessed incidents of abuse.

There was no evidence to support either family members were notified of the witnessed alleged incidents of sexual abuse between Resident's #12 and #13 on six identified dates. The family members of Resident's #12 and #13 were notified the following day more than twelve hours after the witnessed incident.

There was no evidence to support that the witnessed alleged incident of physical abuse between Resident #13 and #24 was reported to the family members at any time.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Notification" states to immediately contact the police if a criminal offence has taken place (e.g. theft, sexual or physical assault). Otherwise, confer with the Regional Director as to whether or not to contact the police.

There was no evidence to support the witnessed incidents of alleged sexual abuse between Resident's #12 and #13 on five identified dates were reported to the police or that the Regional Director was contacted to determine if the police should have been notified. The police were notified for the witnessed incidents reported in two identified reports to the Ministry of Health and Long Term Care but in both instances, the police was not notified immediately.

There was no evidence to support the witnessed alleged physical abuse between Resident's #13 and #24 were reported to the police or that the Regional Director was contacted.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Notification",

indicates the Administrator, Director of Care or designate shall initiate an internal investigation and complete a preliminary report before going off duty. All staff having knowledge of the incident is to remain on duty until they are excused by the person completing the preliminary report. Ensure comprehensiveness of all investigative documentation.

The management team was made aware of the allegations of sexual abuse between Resident's #3611 and #11 on the day following the incident. ADOC #106 and the Administrator were interviewed and were only able to provide an internal incident report completed by the RPN in charge following the incident. The home failed to initiate an investigation into the allegations and failed to complete comprehensive documentation related to this incident.

The alleged witnessed incidents of sexual abuse between Resident #12 and #13 on five identified dates were entered into the twenty four hour report by the staff who witnessed the alleged sexual abuse. According to ADOC #106 and the DOC, the management team reviews all documentation provided in this report during the morning management meetings. There was no investigation or documentation related to any of these incidents. According to ADOC #106, the alleged witnessed sexual abuse of Resident #13 (reported to the management team by means of the twenty four hour report) was discussed during the morning management team meeting the day after the incident. ADOC #106 stated the team determined it was not sexual abuse because they deemed the touching not to be of a sexual nature. ADOC #106 and the Administrator were unable to provide the inspector with documentation to support the completion of an investigation or the decision making into their conclusions.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Evaluation" states, promptly undertake an analysis of every incident of abuse or neglect of a resident at the home after becoming aware of the incident. The evaluation of the abuse policy is outlined in the program evaluation document and must be updated at least annually. The evaluation covers: analysis of the policy related to abuse and neglect, effectiveness of policy to support zero tolerance approach to abuse and neglect, results of all abuse analysis are integrated into the evaluation. Changes recommended and or made to prevent abuse are formalized, communicated and implemented promptly. Ensure that documentation is promptly prepared and kept for all evaluation including the names of persons who participated in the evaluation and the date the changes and improvements were implemented.

On June 17, 2014, the DOC was interviewed in regards to an annual evaluation of the home's zero tolerance of abuse policy. The DOC directed the inspector to speak with S#137 and the home attempted to locate the information requested. At the end of the day June 17, 2014, the DOC advised the inspector the home had not completed an annual evaluation.

The home's compliance history as outlined under LTCHA, 2007 s. 19 was reviewed. The home has demonstrated an ongoing inability to sustain compliance related to abuse reporting and investigation. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (1) (b) whereby the plan of care did not support the goals that the interventions were intended to achieve.

Review of clinical records indicated that on three identified dates, the Morse Fall Assessment was completed and indicated Resident #3692 was at high risk of falls. The clinical records indicated that Resident #3692 had two falls.

Review of the current plan of care indicated under ADL-Toilet use that Resident #3692 requires limited assistance by one staff to transfer on and off the toilet / at times the resident is able to perform this task independently.

Review of the current plan of care indicated a focus of falls, physical limitations, poor balance and failure to recognize limitations. The plan of care included one statement under intervention stated as "Morse Fall risk score high risk dated with an identified date". The plan of care did not included any interventions on how to reduce risk of falling or strategies to achieve stated goal of "Resident will remain fall free over next quarter". [s. 6. (1) (b)]

2. The licensee has failed to comply with LTCHA 2007, s. 6 (1)(c) in that the plan of care for a resident does not set out clear directions to staff and others who provide direct care to the resident.

During a lunch observation, a staff member was heard saying that Resident #29 would not have someone sitting with him/her today as they did not have enough staff. Another staff member then stated that the resident would not sit long enough to eat if there was no staff available to provide assistance.

During the lunch meal, Resident #29 was observed to receive a prescribed diet on a rimmed plate and regular thin fluids. The resident was brought in at the beginning of the meal service and ate the meal very quickly and at times while standing. Staff was not observed to provide 1:1 assistance during the meal service. The resident required staff to re-direct the resident throughout the meal. A staff member escorted the resident out of the dining room and back to his/her room where he/she was observed to be lying in bed. Resident #29 was not offered dessert.

Resident #29's current care plan was reviewed.

Interviews with staff related to Resident #29 indicated the following:

PSW #S162 stated staff will bring the resident in at the end of the meal because he/she eats very fast and there are more staff to assist him/her later in the meal service. PSW #S162 further stated that the Resident really needs 1:1 assistance/supervision during meals since he/she eats very fast, will get up many times during the meal service and at times eats while standing up. She recognized that 1:1 staff assistance/supervision is not part of the resident's written care plan, but

staff feel this is required.

RPN #S151 stated the resident is brought in at the end of the meal service, that he/she needs close supervision and further stated that staff provide the meal all at once (soup, entree and dessert) so that the resident does not get up and wander to other resident's tables.

#S138 and #S142, stated that the resident is on a prescribed diet with thickened fluids. They also stated the resident gets a small spoon and rimmed plate for eating since he/she eats so fast. The PSW's indicated that the resident is brought in at the end of the meal service and is always provided with 1:1 assistance. They further indicated that staff will feed the resident due to the fact that he/she eats very fast.

The Registered Dietitian was interviewed on June 17, 2014 and stated that she does not complete eating assessments and directed this inspector to speak with the Restorative Care Nurse, RPN #S154.

The Restorative Care Nurse, RPN #S154, stated that she has not received a referral to assess Resident #29 related to eating. She stated she felt that all possible interventions were in place for the resident including a rimmed plate, a cup with a lid, 1:1 staff assistance and bringing the resident in at the end of the meal service. When the Inspector mentioned that only one of these interventions was mentioned in the care plan, the staff member suggested looking on the diet roster in the servery.

Upon review, the diet roster for Resident #29 states that the resident is to receive a prescribed diet. There is no mention of a rimmed plate, a cup with a lid, 1:1 staff assistance or thickened fluids. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 r. 8. (1) (b) whereby the system to monitor fluid intake of residents with identified risk is not complied with.

O. Reg. 79/10, s. 68 (2) (d) states every licensee of a long term care home shall ensure that the organized program of hydration include a system to monitor and evaluate the fluid intake of residents with identified risks related nutrition and hydration.

The home's policy #RESI-05-02-05 " Food and Fluid Intake Monitoring" states Food and fluid intake shall be monitored for all residents as an ongoing indicator of nutritional status. Individual resident intake shall be analyzed for significant changes and actions taken and outcomes evaluated.
Policy also states care staff to document resident food and fluid intake after meals, snacks and nourishment . Food and fluid intake must be recorded as close as possible to consumption. Registered staff review food and fluid intake records daily.

On June 11, 2014 during an interview with the Nurse Practitioner and the Assistant Director of Care, both confirmed that the Food and Fluid Intake logs are to be completed by care staff and reviewed by the registered staff daily.

Resident #9 had an identified risk of urinary tract infections.

Review of Resident #9 Food and Fluid Intake log for four identified months as follows:
Identified month #1 there were 62 times without fluid documentation at meals, and/or nourishment.
Identified month #2 there were 75 times without fluid documentation at meals, and/or nourishment.
Identified month #3 there were 82 times without fluid documentation at meals and/or nourishment.
Identified month #4 there were 38 times without fluid documentation at meals and/or nourishment.

On identified dates interviews with S #132, S#131, and S #162 confirm that the food and fluid records are not always documented. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the system to monitor Resident#9's fluid intake is complied with by all staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 24. (2) 1 in that the 24 hour care plan did not include interventions to mitigate the risk of falling for Resident #5.

Resident #5 was admitted to the home on an identified date. The Morse Fall Assessment was completed and documented that the resident was at high risk of falls.

Resident #5 sustained a fall on an identified date. The progress notes were reviewed and indicated the resident was wearing socks when slipped and fell trying to get to washroom. Resident was assessed by RN and assisted back to bed.

ADOC #16 reported that the 24 Hour Care Planning Assessment found in Point Click Care is the twenty-four hour care plan used by the home. The 24 Hour Care Planning Worksheet is used to complete the 24 Hour Care Planning Assessment in Point Click Care.

Both the electronic 24 Hour Care Planning Assessment in Point Click Care and the paper worksheet for Resident #5 were completed within twenty-four hours. Under the "Falls" tab of Resident #5's 24h Care Planning Assessment it was documented that there were potential problems related to falls and that the resident had fallen in the past 31-180 days. No interventions related to falls were documented on the 24 Hour Care Planning Assessment.

Resident #2's 24 Hour Care Plan Assessment did not include interventions to address the resident's risk of falling. [s. 24. (2) 1.]

2. The licensee failed to comply with O. Regs. 79/10, s. 24 (9) whereby Resident #5 was not reassessed when care set out in the plan had not been effective.

Review of resident #5's Community Care Access Centre (CCAC) MDS assessment available to the home on admission indicated poor food and fluid intake.

Review of resident #5's daily nourishment intake and food and fluid intake records for an identified period of time indicated that the resident had reduced food and fluid intakes for 5 days.

Review of resident #5's plan of care indicated that the resident was independent in eating and required set up help for meals. The resident's nutritional risk in relation to the poor food and fluid intake as outlined in the admission information supplied to the home by CCAC upon admission was not included. The plan of care did not include any interventions to address the resident's poor food and fluid intake for the identified period of time.

On June 12, 2014, interview with the Registered Dietitian (RD) S#125 confirmed that no referral was sent to the dietitian and no nutritional assessment was completed for Resident #5 due to poor food and fluid intake. The RD indicated that registered staff would complete the nutrition care plan if the dietitian is not available. [s. 24. (9) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the 24 hour care plan identifies at a minimum any risks the resident may pose to him/herself, including any risk of falling and interventions to mitigate those risks and ensure the resident is reassessed and the care plan reviewed when care set out in the plan has not been effective, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 26 (4) (a) whereby a nutritional assessment for all residents was not completed by the registered dietitian on admission and whenever there was a significant change in a resident's health condition.

Review of clinical records for an identified period of time indicated a referral was sent to dietitian. There is no evidence that Resident #5's nutritional assessment and nutritional risk assessments were completed on admission by the dietitian. Nutritional status under section K of MDS was completed by registered staff.

Review of Resident #5's daily nourishment intake and food and fluid intake records for an identified period of time indicated the resident had reduced food and fluid intakes for five days. The record indicates that the resident refused a minimum of two meals a day for an identified period of time.

On an identified date, RN #124 was interviewed and confirmed that no referral was sent to the dietitian for reduced food and fluid intake for Resident #5 and the resident was not assessed by the Dietitian during the identified period of time.

ADOC#106 indicated when reviewing the food and fluid intake for Resident #5 that the resident's condition falls under significant change that require a referral to the dietitian.

The Registered Dietitian #125 indicated that a referral to the dietitian is sent for risk of dehydration of a resident. The RD confirmed that no referral was sent to the dietitian and no nutritional assessment was completed for Resident #5 due to worsening of condition and poor food and fluid intake. She confirmed that a nutrition priority screen to determine nutritional risk was not completed for Resident #5 on admission and when resident had worsening or significant change in condition.

Review of the home's policy Nutritional Priority Screening Policy # Diet-04-01-06 indicates that all residents shall be screened for nutritional risk on admission, quarterly and with every significant change.

There is no documented evidence that resident #5 was screened for nutritional risk on admission or when resident #5 had a significant change in condition with inadequate food and fluid intake. [s. 26. (4) (a),s. 26. (4) (b)]

2. Resident #21 was admitted to the home on an identified date.

Review of the resident's health care record indicated a referral was sent to the Registered Dietitian on an identified date for an admission assessment.

O. Reg. 79/10, s. 25(1)a states that the assessments necessary to develop an initial plan of care under subsection 6(6) of the act are completed within 14 days of the resident's admission.

The Registered Dietitian did not complete the admission assessment for Resident #21 within the fourteen days. The Oral/Nutritional status, section K, of the admission MDS assessment was completed by registered nursing staff. [s. 26. (4) (a),s. 26. (4) (b)]

3. Resident #23 was admitted to the home on an identified date. A referral was sent to the Registered Dietitian on an identified date to complete an admission assessment. The Registered Dietitian did not complete the assessment within fourteen days of admission. The Oral/Nutritional Status, section K, of the resident's MDS admission assessment was completed by registered nursing staff. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a registered dietitian completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 51 (1) (4) whereby the continence care and bowel management program did not provide for an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff.

During the review of resident health care records, this inspector noted documentation that indicated two residents were utilizing pull-up continence products and that they were being supplied by the family rather than the home. S#130 was interviewed and stated a total of three residents currently living in the home are using pull-up continence products supplied by the family because of personal preference.

On June 17th, 2014 during an interview with S#143, she confirmed that an annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff has not been completed. [s. 51. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to develop and implement annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 72(2)(c) in that they do not have standardized recipes and production sheets for all menus.

On June 11, 2014, the Dietary Supervisor #S104 was interviewed in relation to food quality. When asked if there were standardized recipes for all menu items he stated that they are working towards this, but that currently about twenty percent of their current Spring/Summer menu item recipes are not standardized.

On June 17, 2014, two full-time cooks (staff members #S144 and #S145) were interviewed in relation to standardized recipes. When asked what they would do on a day when they have no standardized recipe they stated they would either make the menu item from memory or they would use the computer to look up a recipe for that particular food item. [s. 72. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there are standardized recipes and production sheets for all menus, to be implemented voluntarily.

WN #10: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73 (1)6 in that not all food is served at a temperature that is safe and palatable to the residents.

Stage 1 of the Resident Quality Inspection involves interviewing forty randomly selected residents (where appropriate) about the care and services of the home, including food quality related to food being served at the appropriate temperature. The following comments were made by residents during this process:
- Resident #3635 indicated not liking the food in the home
- Resident #3640 rated the food as a 1 out of 10 and goes to food basics to purchase food
- Resident #3661 stated that the food looks ok some of the time, but generally eating here is not a good experience. The food does not taste good, it is just passable. The other day they served a cold plate and it was only a deviled egg and a piece of bread. It was not cold and hot food is sometimes cool.
- Resident #3692 stated that food is not good, not appetizing. Today they served chicken on a bun. It looked awful and did not taste good. The chicken was cold and there was hardly any of it. The food is often cold and it should be warm. Some staff won't heat it up like it should be. Potatoes are often cold, meat is often cold. It depends who does it.
- Resident #3719 stated that the food is quite awful. Although it looks appetizing and the menu sounds good, it is rather tasteless and things that you would expect to be warm are almost always cold. Resident also stated there were too many puddings, cookies and cakes and felt there should be more fresh fruit offered. Resident states potatoes are often cold, has stopped eating potatoes as a result. Not mashed potatoes but potatoes cooked any other way. The cooked vegetables are almost

always cold.
- Resident #3588 states the food is very seldom hot, they have changed how they serve the soup for safety reasons and feels it is not hot enough by the time it gets to the table. Resident identified self as being a "stickler" for hot food.

On June 12, 2014 during a dining observation, Resident #16 stated that the hot food is not always hot enough - especially vegetables like carrots.

A review of Resident Council Meeting Minutes showed the following comments:
- March 25, 2014 round table discussion: The quality of food is lacking in temperature (not hot enough for most foods), potatoes are too hard, vegetables need to be cooked "properly", they are not good, a lot of the same food, too much bolognese and elbow macaroni.

Random "HACCP servery daily temperature logs" were reviewed for the weeks of May 18 and May 26, 2014 from the main kitchen and the serveries located on each of the four floors. The following was noted:
- 15 hot and cold entree temperatures were outside the holding temperature requirements listed on the temperature sheet
- 9 hot entree temperatures were below the recommended serving temperature of 160 degrees F (71 degrees C)
- 9 cold vegetable/salad temperatures were outside the holding temperature requirements for cold foods
- 19 hot vegetable temperatures were below the recommended serving temperature of 160-180 degrees F (71-82 degrees C)
- 1 pureed hot soup temperature was below the recommended serving temperature range of 160-180 degrees F (71-82 degrees C)
- 1 fruit temperature was outside the holding temperature requirement for cold foods

The holding temperature requirements listed on the home's HACCP servery daily temperature are as follows:
HOT FOODS: HOLD AT 140 degrees F (60 degrees C) or above
If product temperature is below 140 degrees F (60 degrees C), return to production area for immediate reheating to 165 degrees F(74 degrees C)
COLD FOODS: HOLD AT 40 degrees F (4 degrees C) or below
If product temperature is above 40 degrees F (4 degrees C), remove and quick chill to correct temperature

The HACCP (Hazard Analysis Critical Control Points) Food Safety Quality Assurance

Manual states that critical temperatures are above 60°C (140°F) or below 4°C (40°F) to inactivate or reduce bacterial growth.

During an interview with the Dietary Supervisor on June 12, 2014, he stated that when temperatures are outside the hot and cold holding temperatures staff should either be re-heating or quick chilling according to the instructions on the HACCP servery daily temperature log. He further stated that staff do not always re-record the temperatures once this is done, which he recognized as not being a good practice.

On June 13, 2014 four dietary aids were interviewed in relation to food temperatures. All stated that they would correct temperatures outside holding temperature requirements and if they did this they would record it on the HACCP servery daily temperature log. Two of the four interviewed stated that they almost never see temperatures that need to be corrected.

None of temperatures identified as being outside the holding temperature requirements or the recommended serving temperatures were noted on the log as being corrected.

On June 17, 2014 two full-time cooks were interviewed in relation to food temperature. Both stated they heat hot foods to within the recommended serving temperatures and one indicated this is a "must". They also stated that serveries rarely call down to the main kitchen to have food temperatures corrected. [s. 73. (1) 6.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 in that staff did not use proper techniques to assist residents with eating.

On June 4, 2014, during the initial dining observation of the lunch meal, #S152 was observed feeding Resident #22 while in a standing position. On the same date, a personal support worker (PSW) student was observed providing feeding assistance to a resident in the lounge area while in a standing position.

On June 12, 2014, a PSW student was observed at the lunch meal feeding Resident #3596 while in a standing position.

On June 17, 2014, staff member #S152 was observed at the lunch meal providing feeding assistance to Resident #3596 and Resident #22 while in a standing position. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are being served at a temperature that is both safe and palatable to the residents and that staff use proper techniques to assist residents with eating, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 74(2) in that the Registered Dietitian (RD) who is a member of the staff of the home was not on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

The Registered Dietitian (RD) for the home was interviewed and confirmed she was on leave from the home from February 4 to March 24, 2014.

The Administrator of the home indicated that during this time a Registered Dietitian from Extendicare provided coverage.

An email was received from this RD, #S156, stating that she was on site in the home on February 12, 25 and 28, 2014 and worked a full day (8 hours) each time.

The home required 84 hours of Registered Dietitian time for the month of February 2014 (168 residents) and 84.5 hours for the month of March 2014 (169 residents). Full capacity of the home is 170 residents.

For the month of February 2014, the home had 32 hours of RD time. (4 days x 8 hours)
For the month of March 2014, the home had 32 hours of RD time. (4 days x 8 hours). [s. 74. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a Registered Dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 229 (4) whereby all staff do not participate in the implementation of the infection and prevention and control program.

The following observations were made:

June 9/14, an identified shared bathroom had magazines stored on the back of the toilet,
June 4 and June 9/14, an identified shared bathroom was observed to have unwrapped toilet paper on the back of the toilet,
June 4 and June 9/14, an identified shared bathroom was observed to have an unlabelled urinal stored on the back of the toilet, and
June 4 and June 9/14, an identified shared bathroom was observed on the back of the toilet to have two unlabelled urinals and a urine collection container labelled with the name of a resident that does not share this bathroom. Additionally, an opened bottle of saline and a blue bulb syringe was stored next to the resident sink. S#101 was interviewed and indicated these are utilized to irrigate a resident catheter. S#103 was also interviewed and stated the equipment should not be stored on the resident's counter.

The infection control lead S#100 was interviewed. She agreed the storage of personal items on the back of toilets does present a risk of cross contamination and the practice should not be done. She also stated that a resident that requires a urinal on an ongoing basis should be utilizing one that is labelled with their name. Otherwise, all other urinals being used on an occasional or one time basis are to be returned to the dirty utility room for sanitizing after use. She further stated the equipment utilized for the irrigation of the resident's catheter and the urinals should have been bagged, labelled with the resident name and stored in the resident specific area to prevent cross contamination. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all staff participate in the infection prevention and control program to minimize the risk of cross contamination to residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, s. 3 (1)(11)(iv) whereby the resident has not had his or her personal health information kept confidential.

On an identified date, S#129 administered the noon medications to Resident's #18, #19, and #20 and left their personal health information pertaining to medication open and visible on the Electronic Medication Management System Screen.

The Electronic Medication Record monitor was visible to the three residents sitting at a table in the area. Confidentiality with respect to the three resident's personal health medication profile was not protected or maintained. [s. 3. (1) 11. iv.]

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 37(1)(b) in that resident equipment was not kept clean.

On June 11, 2014 at 1134 hours, Resident #3692's commode was observed. The inside had been cleaned out, a new bag in place. The seat of the commode was soiled with a large amount of dried feces and the outside bottom piece of the commode was also soiled with some dried feces.

On June 11, 2014 at 1601 hours, Resident #3692's commode was observed in the same condition as at 1134 hours.

On June 12, 2014 at 1143 hours, Resident #3692's commode was observed with a new bag but the seat was still soiled with dried feces. It appeared to have been cleaned since the day prior, since there was not as much but did not appear to have been wiped down after last use.

On June 11, 2014 at 1611 hours, Resident #16's personal commode was observed. The inside of the commode was observed to be clean with a new, unsoiled bag present. A small amount of dried feces was observed on the seat.

On June 12, 2014 at 1152 hours, Resident #16's personal commode was observed to have been wiped down from the day before, but currently had a small amount of dried feces on the back of the seat of the commode. The bag inside the commode had been changed and was unsoiled.

Resident #16 was interviewed on June 11, 2014 and stated that he/she uses the commode often. When asked if staff clean it regularly, the resident said it depends on the staff. Stated that some staff will leave it by the door for about an hour and it will smell and others clean it right away. When asked if staff clean the outside and seat of the commode, the resident stated again it depends on the staff member. Sometimes they do not.

On June 11, 2014, PSW #S141 stated that commodes are emptied as needed, there is no set schedule. She stated that the cleaning of the outside of commodes and the seats is done once per night by the night shift PSWs. When asked if there was feces on the commode seat , she said that it would be cleaned right away by the PSW and she showed me the wipes that they use for this.

On June 12, 2014, ADOC #S106 was interviewed in relation to the cleaning of resident commodes. She stated that the expectation is that PSWs empty commodes right away, when possible, and that they wipe them down completely after each use, including the seat. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007 s. 15 (2)(c) in that the home, furnishings and equipment are not maintained in a good state of repair.

The following observations were made during the inspection:
- Rm 103 - wall surface behind toilet has rust coloured staining on tiles
- Rm 105 - wall surface behind toilet has rust coloured staining on tiles

- Rm 107 - wall surface behind toilet has rust coloured staining on tiles
- Rm 111 - wall surface behind toilet has rust coloured staining on tiles with raised areas of a hard white substance
- Rm 122 - areas of paint missing on grab rails in resident's bathroom (103)
- 2nd floor hallway - hole in wall down by end of hallway in wing C on right hand side just before sitting area (197)
- Rm 407 - broken plastic strips on the wall above the light switch at the entrance of the room, black marks wall, bedroom and bathroom doors
- Rm 410 - Lower corner of the wall in front of the resident's closet in disrepair, drywall missing and steel corner showing; pieces of drywall damaged above the head of the bed; left wall has long black mark
- Rm 413 - Broken drywall at the outside corner of the closet; ill fitting right window screen.
- Rm 430 - bathroom: paint removed/chipped above the toilet and sink, and also on the grab bars; two ill-fitting ceiling tiles in bathroom with chipped edges (531) [s. 15. (2) (c)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(a) in that the resident-staff communication response system is not easily accessed by residents, staff and visitors at all times.

The call bell in Resident #3593's bathroom was observed on June 10th and 11th, 2014 to be wrapped around the grab bar beside the toilet multiple times and could not be activated when pulling the end of the cord.

The call bell in Resident #3635's bathroom was observed on June 5th, 9th and 11th, 2014 to be wrapped around the grab bar beside the toilet multiple times and could not be activated when pulling the end of the cord. [s. 17. (1) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 37 (1) (a) whereby resident personal items and personal aides such as dentures, glasses and hearing aides were not labelled within 48 hours of admission and of acquiring, in the case of new items.

The following unlabelled personal items and personal aides were found as follows:

-June 5/14, an unlabelled pink hair brush in the second floor tub room at the end of C wing,
-June 5 and June 9/14, an identified shared bathroom contained unlabelled combs and two unlabelled denture containers,
- June 4 and June 9/14, an identified shared bathroom contained an unlabelled denture cup on the bathroom counter,
-June 5 and June 9/14, an identified bathroom contained unlabelled tubes of toothpaste, and one unlabelled denture cup with dentures inside,
-June 5 and June 9/14, an identified bathroom contained unlabelled make up in a box left on the bathroom counter,
-June 4 and June 9/14, an identified shared bathroom contained an unlabelled toothbrush and denture cup, lotion and denture cleaning tabs,
-June 4 and June 9, an identified bathroom contained an unlabelled hair comb, shave cream brush, and three tubes of toothpaste, and
-June 4 and June 9/14, an identified bathroom contained unlabelled deodorant, hair comb and mouth wash. [s. 37. (1) (a)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 57 (2) whereby the licensee did not respond in writing to the Resident Council within ten days of receiving a concern or recommendation.

On June 4, 2014, the President of the Resident Council was interviewed and stated he could not recall if the Resident Council received written responses within ten days when a concern or recommendation is brought forward.

The Resident Council minutes for February, March, April, and May, 2014 were reviewed. Twelve concerns or recommendations were identified in the minutes and no written responses were provided to the Resident Council within ten days regarding any of the issues.

On June 9, 2014, the Administrator confirmed that a written response is not provided to the Resident Council within 10 days of receiving concerns or recommendations. [s. 57. (2)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA ,2007, s. 60 (2) whereby the licensee did not respond in writing to the Family Council within 10 days of receiving a concern or recommendation.

On June 4, 2014 the President of the Family Council was interviewed and stated she could not recall if the Family Council received written responses within ten days when there is a concern or recommendation brought forward.

On June 9, 2014, the Family Council minutes for February, March, and April 2014 were reviewed. Seven concerns or recommendations were identified in the minutes and no written responses were provided to Family Council within ten days regarding any of the issues.

On June 9, 2014, the Administrator confirmed that a written response is not provided to the Family Council within ten days of receiving concerns or recommendations. [s. 60. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 129 (1)(a)(ii) whereby drugs that are stored in an area or a medication cart are secure and locked.

On June 9, 2014, S#128 administered medications at 1200 hours to Resident #27 and #28 in their rooms with the resident doors closed leaving the cart unlocked and out of the sight of the registered staff member.

On June 9, 2014, S#129 was observed leaving the medication cart unlocked while administering noon medications to residents #3640, #3605, #3718, #18, #19, and #20. The cart was not within sight of the nurse during these times.

On June 12 and 13, 2014, topical treatment medications were left unlocked on the Personal Support Workers supply carts on the second, third and floor home areas. [s. 129. (1) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 130(2) whereby access to the medication storage area are not restricted to persons who may dispense, prescribe or administer drugs in the home.

On June 6th, 2014, S#130 provided inspector #531 with access to the "Medical Pharmacy Room" with an access key in his/her possession. S#130 is not a member of the registered staff and is not able to dispense, prescribe or administer drugs in the home. [s. 130. 2.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #901	2014_179103_0015	103

Issued on this 14 day of August 2014 (A1)

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DARLENE MURPHY (103) - (A1)

Inspection No. / No de l'inspection : 2014_179103_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-000278-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 14, 2014;(A1)

Licensee / Titulaire de permis : THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street, KINGSTON, ON, K7L-2Z3

LTC Home / Foyer de SLD : RIDEAUCREST HOME
175 RIDEAU STREET, KINGSTON, ON, K7K-3H6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Debra A Green

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

Ministère 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

To THE CORPORATION OF THE CITY OF KINGSTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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).

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 :

The licensee shall ensure all doors leading to non-residential areas are 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.

Grounds / Motifs :

1. The licensee has failed to comply with O. Regs 79/10 s. 9 (1) 2 whereby a door leading to a non residential area was not closed and locked when not being supervised by staff.

The floor to ceiling gated entrance into the kitchen on the lower level was observed by the inspector to be ajar by approximately one meter. From the entrance opening, the inspector was able to see steam coming from a large vat located inside a second open door in the kitchen preparation area. The inspector entered directly into the kitchen and noted a large metal vat that contained boiling water. There were no staff in attendance of this area for the five minutes the inspector was present. This access to the kitchen is adjacent to the coffee shop and seating area that is used on a regular basis by staff, residents and family members.

The Dietary Supervisor advised that the gate currently has a non functioning magnetic lock and keypad. In the interim, the gate has been equipped with an alternative locking mechanism which consists of a padlock and a rod that secures into the floor. At this time, the key to the padlock could not be located.

The Administrator was interviewed and stated a locksmith has been contacted and the locking mechanism will be repaired tonight. The door will be supervised until such time that the lock is repaired. (103)

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

Jun 17, 2014

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 :

(A1)
The licensee is hereby ordered to prepare, submit and implement a plan to include the following:

-all direct care staff to complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners on all forms of abuse. The education should include but not be limited to:

-how to identify all forms of resident abuse as defined by the O. Regs 79 10 s. 2,
-the difference between consensual and non-consensual sexual touching with a focus on residents that have a cognitive impairment,
-the mandatory reporting obligations as outlined in the LTCHA, 2007 s. 24 to immediately report all alleged, suspected or witnessed incidents of abuse to the Director,
-the use of the Abuse Decision Trees to assist in the decision to report and investigate allegations of resident abuse,
-the legislated reporting time lines for the notification of the resident s substitute decision maker in accordance with O. Regs 79 10 s. 97,
-the legislated reporting time lines for the notification of the police in accordance with O. Regs 79 10, s. 98.

The plan shall also include how the home will measure the effectiveness of the education to ensure sustained compliance and the actions the home will take if non compliance is identified.

The plan shall be submitted in writing by fax to Inspector, Darlene Murphy at 613-569-9670 on or before July 7, 2014. The plan shall identify who will be responsible for each of the corrective actions listed.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, s. 19 (1) (a) whereby residents were not protected from sexual abuse.

Sexual abuse is defined by the LTCHA, 2007 as "any non-consensual touching,

behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member."

On an identified date, S#134 observed Resident #3611 approach a co-resident, proceeded to hug the resident and then placed his/her hand over the breast area of Resident #11. Resident #11 has a diagnosis of Alzheimer's disease. S#134 stated she told Resident #3611 to get away from the resident and assisted Resident #11 to the circle area in the home away from Resident #3611. S#134 stated she immediately reported the incident to the charge nurse on the unit as she viewed this as sexual abuse.

ADOC #106 was interviewed and stated she received notification of this incident the following day by means of the twenty four hour report. She stated the twenty four hour report is generated each morning during the week days and reviewed by the management team during the daily morning meetings for any outstanding issues that may require follow up. The ADOC stated the twenty four hour report is not to be used for anything that requires the immediate attention of the management team. The home has an on-call manager who would be contacted for any urgent issues that occur outside of regular business hours.

The DOC also confirmed that the twenty four hour report is reviewed in the daily morning management meetings and also confirmed a seventy two hour report is generated every Monday so the management team can review any issues that arose over the weekend. The DOC further stated the charge nurses on the weekend are also expected to review the twenty four hour reports as a part of their charge nurse duties.

The Director and the police were notified of this incident by ADOC #106, some eleven hours after the incident had occurred.

Resident #12 and Resident #13 are both diagnosed with a cognitive impairment. During a review of Resident #12's progress notes the following incidents were recorded:

On an identified date, S#110 observed Resident #12 touching Resident #13's breasts. S #110 was interviewed and stated she recalled the incident. She advised the inspector it was a known behaviour and that both families were aware. She stated she wasn't sure if she viewed the resident's actions as an alleged sexual

abuse as she felt it's a grey area when dealing with two cognitively impaired residents. S#110 stated she did not believe the resident to be a sexual predator and that Resident #12 only seeks out this one resident. The staff member stated two cognitively impaired residents cannot give consent and that non-consensual touching is considered an alleged sexual abuse. She stated she did not report this incident to anyone, but did attach her progress note to the twenty four hour report. There was no evidence that resident consent was assessed at the time of the incident.

Upon review of Resident #12's and #13's progress notes and plans of care from an identified date to the date of this incident, there was no indication this type of behaviour had previously been observed between these two residents and there was no indication the families of either resident were notified of the incident.

On another identified date, S#108 observed Resident #12 putting his/her hands up Resident #13's shirt. The staff member was interviewed and stated she reported the incident immediately to the RPN in charge and ensured the two residents were separated. S#108 stated she believed the actions were inappropriate and that it could be considered sexual abuse. She stated she knew it needed to be reported to the staff. RPN S#159 was contacted by telephone for an interview and a call back number was provided but not returned. The progress note in the resident's chart was reviewed and the note was included as a part of the twenty four hour report. There was no evidence that resident consent was assessed at the time of the incident. The twenty four hour report was reviewed and did contain documentation related to this incident. ADOC #106 could not explain why this incident was not reviewed during the morning management meeting. There was no indication either family members were notified of the incident.

On another identified date, RPN S#159 observed Resident #12 rubbing Resident #13's breasts. A progress note was made and the note was included in the twenty four hour report. RPN S#159 completed an responsive incident report on the day of the incident and this report was revised the following day to indicate the Registered Nurse in charge and both family members had been notified the day after the incident. The legislated time line for the notification of the substitute decision maker of this incident is within twelve hours of the incident.

According to the ADOC #106, S#159 did not immediately notify management and that the twenty four hour report was how the team was advised of the allegation. CIATT (Centralized Intake Assessment and Triage Team) was contacted to

determine the time the home notified the Ministry of Health and Long Term Care. The SAC (Spill Action Centre) report indicated, a call was received by the after hours pager on the date of the incident at approximately 1637 hour. The caller indicated the alleged incident of sexual abuse occurred at 1400 hour despite the progress note being entered onto Resident #13's electronic progress notes at 1247 hours and the critical incident report indicating 1250 hour as the time of the incident.

The Administrator asked to clarify the expectation of immediate reporting. The Administrator was advised the reporting is to be as soon as possible in the circumstances without delay. Any circumstances that delay the reporting should be reasonable and without any unexplained or unreasonable delay.

ADOC #106 was asked to describe the investigation into the allegations of sexual abuse between Residents #12 and #13. She stated the management team discussed the incident at the management morning meeting the following day and determined the incident not to be sexual in nature. The team did not believe Resident #12 touched the co-resident's breasts. The ADOC further stated the staff stated Resident #12 often touches Resident #13's arms, face etc. but that the resident doesn't mean anything by it and the staff did not believe the resident's breast had been touched. The ADOC stated staff reported Resident #12 seeks Resident #13 out and possibly believes this resident to be a spouse. The ADOC was asked why the staff member charted the resident was touching the co-resident's breasts and the ADOC stated she didn't know why. Although RPN S#159 could not be interviewed, this inspector considered the documentation to be accurate. RPN S#159 documented Resident #12 touching Resident #13's breasts in the resident's progress notes as well as the internal incident report.

ADOC #106 and the Administrator were asked for the home's investigation notes and were unable to provide any written documentation or statements to support that an investigation had taken place.

On another identified date, RPN S#136 observed Resident #12 approaching the co-resident and started to rub Resident #13's breasts. The staff member was interviewed and stated the staff immediately intervened to separate the residents when it happened. She recalled Resident #12 was unhappy about being taken away from Resident #13 and further stated this had been an ongoing problem between these two residents. RPN S#136 stated she did not report the incident to anyone else at that time, but did make a progress note and ensured the note would be included in

the twenty four hour report because this goes to the management team. S#136 was asked if she viewed this incident as an alleged abuse and she stated yes. The staff member stated it was the reason Resident #13 had to be moved to another unit. RPN S#136 stated the resident didn't like being touched by Resident #12 and it made the resident nervous and upset. ADOC #106 could not explain why the information pertaining to this alleged sexual abuse had not been reviewed in the morning management meeting.

On another identified date, RPN S#129 observed Resident #12 rubbing Resident #13's breasts. The staff member stated the residents were immediately separated. RPN S#129 stated the incident was not reported to anyone else in the home or to the family members. A progress note was made and it was included in the twenty four hour summary. RPN S#129 stated they knew it wasn't right for a resident to touch another resident's breasts and stated the incident was seen as "cute". RPN S#129 did not feel it would be sexual abuse because both residents are cognitively impaired. There was no indication that resident consent was assessed at the time of the incident. ADOC #106 could not explain why the information pertaining to this alleged sexual abuse had not been reviewed in the morning management meeting.

Two of the above incidents occurred during the weekend and, according to the DOC, the twenty four hour report should also have been reviewed by the Registered Nurse in charge for that weekend.

RPN S#109 was interviewed and stated Resident #12 had taken a fond liking to Resident #13 and believed the resident may have thought it was a spouse. She stated the resident sought the co-resident out to the point that staff could not place Resident #13 in the common area. The resident was relocated down one of the care wings because Resident #12 did not go down that wing. S#109 stated she had conversations with Resident #13's family because she felt it was now unfair and isolating to the resident to remain on the same unit as Resident #12. Resident #13 was moved to another unit.

RPN S#109 was asked why the alleged sexual abuse between Resident #3611 and Resident #11 resulted in a more immediate action (referral to Geriatric psychiatry, medications reviewed and the resident was relocated to another area in the home). She stated she believed there is not a consistent approach in how these types of behaviours are responded to or reported.

Resident #12's plan of care was reviewed from the date of the first incident involving Resident #13 until the date of this inspection and there were no documented interventions in regard to these repeated incidents.

Resident #13's plan of care was reviewed for the same time period and there were no interventions documented in regard to these repeated incidents. Resident #13 was eventually moved to another unit.

The licensee has failed to comply with LTCHA, 2007 s. 19 (1) whereby residents are not protected from physical abuse.

Physical abuse between residents is defined by the LTCHA, 2007 as, "the use of physical force by a resident that causes physical injury to another resident."

During a review of Resident #12's progress, an entry was noted on an identified date whereby Resident #24 approached Resident #12 and squeezed the co-resident's hand which resulted in an injury. The ADOC #106 was interviewed, stated she remembered the incident, agreed it would be an alleged physical abuse and believed an incident report had already been sent to the ministry. The ADOC was unable to find documentation to support the immediate notification of the Director or any submission of a mandatory report. There was no evidence to support the families of Resident's #13 and #24 had been notified and there were no investigative notes related to this incident of abuse.

The licensee has failed to comply with LTCHA, s. 19 (1) whereby residents were not protected from financial abuse.

Financial abuse is defined by the LTCHA, 2007 as "any misappropriation or misuse of a resident's money or property."

On an identified date, S#113 was interviewed in regards to the financial status of Resident #15's account. According to S#113, the police were notified on an identified date to report suspicions of financial abuse.

On another identified date, S#113 reported to the inspector that the home had another alleged financial abuse involving Resident #3700 and provided the inspector with the date the police were notified of the need to investigate the allegations of financial abuse.

The Director of Care was interviewed and asked if the allegations of financial abuse had been reported to the Director for these two residents . She stated they had not yet been reported because nothing had been proven. The DOC was reminded that all allegations of resident abuse require immediate reporting to the Director.

The Administrator and S#113 approached this inspector and advised they had reviewed their records and wished to report two more allegations of financial abuse that had not yet been reported to the Director involving Resident #25 and Resident #26. The documentation for the two accounts was provided to the inspector including the dates the police had been contacted for allegations of financial abuse.

All four allegations of financial abuse were not immediately reported to the Ministry of Health and Long Term Care Director.

The home's compliance history was reviewed for the past three years. In April 2014, the home was issued a Written notification (WN) and a Voluntary Plan of Correction (VPC) for failing to comply with the LTCHA, 2007 s. 24 (failure to immediately report instances of alleged abuse to the Director) and a WN for abuse policy not complied with.

In November 2012, the home was issued a WN and a Compliance order (CO) for failing to notify the Substitute Decision Maker (SDM) of incidents of abuse, a WN for failing to immediately investigate allegations of abuse and a WN for failing to immediately report allegations of abuse to the police.

In October 2012, the home was issued a WN and a VPC for failing to immediately investigate allegations of abuse.

In August 2011, the home was issued a WN and a VPC for failing to immediately report allegations of abuse to the Director

The home has demonstrated an ongoing inability to sustain compliance related to abuse reporting and investigation.

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

Ministère 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

(103)

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

Sep 15, 2014(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to include the following:

-ensure all management staff, including Registered Nurses, all Department Managers, Assistant Directors of Care, Director of Care, the Administrator and anyone else the home determines should be included, receives training to include but not limited to:

-reporting obligations of a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident to immediately report to the Director (LTCHA, 2007 s. 24),

-Notification of substitute decision makers of an alleged, suspected or witnessed incident of abuse (O. Regs 79 10 s. 97),

- Police notification of an alleged, suspected or witnessed incident of abuse (O. Regs 79 10 s. 98),

-how to conduct an investigation into every alleged, suspected or witnessed incident of abuse of a resident by anyone (LTCHA, 2007 s. 23),

-how to complete documentation related to the investigation,

-when and how to undertake an analysis of every alleged incident of abuse,

- how to utilize the results of all abuse analysis and integrate the data from the analysis to thoroughly evaluate the abuse policy at least annually (O. Regs 79 10 s. 99),

The home shall also develop a process for the ongoing monitoring of compliance with the zero tolerance of abuse policy.

The plan should be submitted in writing by fax to Inspector, Darlene Murphy at fax # 613-569-9670, no later than July 7. The plan shall indicate who will be responsible for ensuring the completion of the tasks.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, s. 20 (1) whereby the home's written policy that promotes zero tolerance of abuse and neglect of residents was not complied with.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Policy

Statement" states, "every person in the home has a mandatory and legal obligation to immediately report suspected or witnessed abuse. Under "Procedures", the policy further indicates to immediately report any suspected or witnessed abuse to the Administrator, Director of Care or their designate and the incident must be reported to the MOHLTC Director.

On four identified dates the home contacted the police to report suspicions of financial abuse of Resident's #15, #25, #26 and #3700. The Administrator confirmed she was aware of these incidents. As of June 17, 2014, the four alleged financial abuses had not been reported to the Director.

On an identified date, a documented incident of physical abuse between Resident's #24 and #13 was noted in the progress notes. The ADOC #106 was interviewed, stated she remembered the incident, agreed it would be an alleged physical abuse and believed an incident report had already been sent to the ministry. The ADOC was unable to find documentation to support the immediate notification of the Director or any submission of a mandatory report.

On six identified dates, staff witnessed incidents between Resident's #12 and #13 that constituted allegations of sexual abuse. None of the witnessed incidents were immediately reported. On another identified date, an alleged sexual abuse occurred between Resident's #3611 and #11. This alleged sexual abuse was reported on the incident date to the Ministry of Health and Long Term Care's after hours pager on or about 1637 hours when the incident reportedly occurred on or about 1250 hour.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Notification" states, the resident substitute decision maker is to be notified immediately of any alleged, suspected or witnessed incidents of abuse that result in physical injury or pain or distress and within twelve hours of becoming aware of any other alleged, suspected or witnessed incidents of abuse.

There was no evidence to support family members were notified of the witnessed alleged incidents of sexual abuse between Resident's #12 and #13 on six identified dates. The family members of Resident's #12 and #13 were notified of the witnessed alleged sexual abuse that occurred on an identified date more than twelve hours after the witnessed incident.

There was no evidence to support that the witnessed alleged incident of physical

abuse between Resident #13 and #24 was reported to the family members at any time.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Notification" states to immediately contact the police if a criminal offence has taken place (e.g. theft, sexual or physical assault). Otherwise, confer with the Regional Director as to whether or not to contact the police.

There was no evidence to support the witnessed incidents of alleged sexual abuse between Resident's #12 and #13 on five identified dates were reported to the police or that the Regional Director was contacted to determine if the police should have been notified. The police were notified for two of the witnessed incidents but not immediately.

There was no evidence to support the witnessed alleged physical abuse between Resident's #13 and #24 were reported to the police or that the Regional Director was contacted.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Notification", indicates the Administrator, Director of Care or designate shall initiate an internal investigation and complete a preliminary report before going off duty. All staff having knowledge of the incident is to remain on duty until they are excused by the person completing the preliminary report. Ensure comprehensiveness of all investigative documentation.

The management team was made aware of the allegations of sexual abuse between Resident's #3611 and #11 on an identified date. ADOC #106 and the Administrator were interviewed and were only able to provide an internal incident report completed by the RPN in charge following the incident. The home failed to initiate an investigation into the allegations and failed to complete comprehensive documentation related to this incident.

The alleged witnessed incidents of sexual abuse between Resident #12 and #13 on five identified dates were entered into the twenty four hour report by the staff who witnessed the alleged sexual abuse. According to ADOC #106 and the DOC, the management team reviews all documentation provided in this report during the morning management meetings. There was no investigation or documentation related to any of these incidents. According to ADOC #106, the alleged witnessed

sexual abuse of Resident #13 (reported to the management team by means of the twenty four hour report) was discussed during the morning management team meeting on the morning following the incident. ADOC #106 stated the team determined it was not sexual abuse because they deemed the touching not to be of a sexual nature. ADOC #106 and the Administrator were unable to provide the inspector with documentation to support the completion of a investigation or the decision making into their conclusions.

The home's abuse policy, "Resident abuse", OPER-02-02-04 under "Evaluation" states, promptly undertake an analysis of every incident of abuse or neglect of a resident at the home after becoming aware of the incident. The evaluation of the abuse policy is outlined in the program evaluation document and must be updated at least annually. The evaluation covers: analysis of the policy related to abuse and neglect, effectiveness of policy to support zero tolerance approach to abuse and neglect, results of all abuse analysis are integrated into the evaluation. Changes recommended and or made to prevent abuse are formalized, communicated and implemented promptly. Ensure that documentation is promptly prepared and kept for all evaluation including the names of persons who participated in the evaluation and the date the changes and improvements were implemented.

On June 17, 2014, the DOC was interviewed in regards to an annual evaluation of the home's zero tolerance of abuse policy. The DOC directed the inspector to speak with S#137 and the home attempted to locate the information requested. At the end of the day June 17, 2014, the DOC advised the inspector the home had not completed an annual evaluation.

The home's compliance history as outlined under LTCHA, 2007 s. 19 was reviewed. The home has demonstrated an ongoing inability to sustain compliance related to abuse reporting and investigation.

(103)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Sep 15, 2014(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 14 day of August 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY - (A1)

Service Area Office /
Bureau régional de services : Ottawa