Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_505103_0052	026101-17, 028931-17, 029199-17	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 24, 27, December 18- 22, 2017, January 3, 4, 2018.

**Log #026101-17 (complaint related to various areas of resident care),
Log #028931-17 (alleged incidents of staff to resident neglect),
Log #029199-17 (resident fall that resulted in injury).**

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Environmental Services Supervisor, the Assistant Directors of Care (ADOC), Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector conducted walking tours of the resident home areas, made resident observations, observed availability of linens, reviewed resident health care records, infection control practices including cleaning practices during an outbreak, home's policies related to mechanical lifts, the zero tolerance of abuse policy, the home's drug destruction policy and the home's protocol related to resident safety checks, reviewed wound and skin care practices and the home's staffing plan.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing**

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

10 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure residents #001, #002, #021, and #022 were protected from incidents of alleged staff to resident neglect.

The Long Term Care Home Act, 2007, defines resident neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The following findings are related to Log #026101-17:

Resident #002 was admitted to the home in an identified year and had identified diagnoses. On a specified date, on or about 1600 hour, RPN #117 was administering medications and noted that she was unable to locate resident #002. The staff were asked to look for the resident and found the resident seated on the toilet in the shower room at approximately 1645 hour. The resident was noted to be leaning to the right and had no brief on. Three PSW's assisted the resident to stand and provided resident #002 with care. The resident was noted to have redness on the buttocks area from the toilet seat and was unsteady when ambulated.

RPN #117 was interviewed and stated none of the staff, including herself, had seen resident #002 since their arrival on shift at 1500 hour. The RPN stated the resident was usually either in their room or in the centre core seating area. The RPN was asked to show this inspector where the resident was found. The RPN took the inspector to the shower room located across from the centre core seating area and indicated this room also has a toilet. The door was noted to have a push code access and the RPN confirmed this door was to be closed and locked at all times.

The RPN stated she felt this was a possible incident of resident neglect as she assumed the resident had been placed on the toilet by day staff and forgotten there. The RPN stated the day shift had not communicated to the evening shift that resident #002 was on the toilet. Additionally, the RPN stated the staff on evenings had not completed their safety checks of the resident which led to the delay in finding resident #002. RPN #117 indicated after assessing the resident, she notified ADOC #123 of the incident. The RPN stated the ADOC directed her to ensure the staff were completing their safety checks and that the incident would be managed internally. RPN #117 documented the details of the incident in the resident progress notes which included where the resident was found.

ADOC #123 was interviewed and confirmed she was the manager on call and recalled being made aware of the incident involving resident #002. The ADOC was asked to describe the investigation that was completed in response to this incident. The ADOC stated she was told by RPN #117 the resident had been found in the bathroom across from the shower room, not the locked shower room. She stated she believed the resident had toileted themself and therefore did not further investigate the incident. The ADOC stated she asked to have the resident assessed for injuries and told the RPN to ensure staff were completing hourly checks.

The Administrator was interviewed and stated she recalled being told about this incident by ADOC #123 the following morning, but no further action was taken. The Administrator stated she was told the resident was found in the bathroom across from the locked shower room and was told this was not unusual for this resident, therefore, no further investigation was completed. The inspector indicated the notes in point click care supported the finding of the resident in the shower room and questioned if there were any concerns related to the length of time the resident went unchecked. The Administrator agreed further investigation should have been done based on the fact the resident had not been checked during the first two hours of the shift. To date of this inspection, a critical incident was not been submitted by the home and notifications to the Ministry of Heath and Long Term Care (MOHLTC) or the family were not made related to the alleged staff to resident neglect.

Resident #001 was admitted to the home in an identified year and had identified diagnoses. On a specified date, resident #001 was being assisted by PSW #126 to have a tub bath. The resident was sitting in the sling during the bath when one of the leg straps of the sling became detached from the lift. The resident began to turn sideways in the tub. The PSW activated the emergency alarm and additional PSW staff came to assist by replacing the sling and assisting the resident out of the tub. The resident was

documented as having expressed fear related to the incident throughout the two shifts that followed.

The resident was interviewed and could not recall all of the details, but indicated they remembered turning sideways in the tub and believed this happened because the sling had not been properly applied. Resident #001 stated the incident had frightened them.

RPN #119 was interviewed and stated the PSW staff did not report the incident to her until the end of the evening shift. According to the RPN, she notified RN #127 of the incident at that time. RN #127 was interviewed and stated she was not made aware of the incident until the following day when she reported for work on the evening shift. The RN indicated ADOC #124 had asked her to interview the staff that had worked the previous evening to get the details of the incident.

ADOC #124 was interviewed and stated she was the on call manager on the identified dates. She stated she became aware that something had occurred involving resident #001 on the following morning at approximately 0800 hour. The ADOC was asked to provide any investigation notes related to this incident and gave the inspector two emails. According to the ADOC, she had heard rumours that morning that something had occurred involving resident #001 on the previous evening and that it involved a sling and the resident having a tub bath. The ADOC stated there had been no documentation in the progress notes to reflect any incident and the ADOC did not know if the resident had fallen or any additional details of the incident.

The ADOC was asked what actions were taken in regards to hearing this information and she stated she asked RN #127 to interview the staff when she came onto shift later that day at 1500 hour. The one email given to the inspector outlined the results of the interview with staff. The second email was sent by ADOC #124 to ADOC #123 following the interviews at 1602 hour. The email stated the clip on the resident's sling was worn and that the resident did not go under the water and was safe.

ADOC #124 delayed investigating the incident for approximately seven hours after being made aware that an incident involving resident #001 had occurred the previous evening. ADOC #124 indicated upon completion of the interviews with the staff, she did not feel the incident was reportable but was unable to make that determination until after the investigation was completed.

On another specified date, resident #001 was found on the commode at 1555 hour by

the evening staff. According to the progress notes, the resident's call bell was not within reach, the resident was "very upset" and the resident's buttocks and thighs were found to be reddened. The resident was interviewed and stated they had been left on the commode for more than an hour and was unable to call for assistance because they could not reach the call bell. The resident stated it was uncomfortable being left for that length of time and pointed to the commode stating, "it isn't very comfortable as you can see."

RPN #125 documented in the resident progress notes that she notified RN #108 regarding this incident. The RPN was not available for interview. RN #108 was interviewed and confirmed she was advised of this incident. The RN stated she believed the incident constituted resident neglect because the resident did not have access to the call bell. The RN stated she recalled the on call manager was ADOC #123. The RN stated the ADOC had told her "not to worry about it" and that the ADOC would follow up Monday (the following day). The RN stated she did not hear anything further in regards to this incident

ADOC #123 was interviewed and stated she had no notes to reflect the notification of this call. The Administrator was interviewed and confirmed no further investigation had been completed and no actions had been taken by the home to address this incident. To date of this inspection, a critical incident has not been submitted by the home and notifications to the MOHLTC or the family were not made in regards to either incidents involving resident #001.

The following finding relates to Log #028931-17:

On a specified date, PSW #128 had observed residents #021 and #022 fully dressed at 0740 hour. The PSW asked PSW's #130 and #105 if both residents had already been bathed and the PSW's indicated they had.

PSW #128 reported to RPN #129 that she suspected PSW's #130 and #105 had not provided personal care to residents #021 and #022 as outlined in their plan of care. No further action was taken by RPN #129 in regards to this alleged staff to resident neglect.

ADOC #124 was interviewed and stated PSW #128 brought the issue forward to management on the following morning as she believed there had been no follow up the previous day. The ADOC indicated the home began to investigate the allegation immediately. During the investigation it was reported that resident #021 had been

bathed, but the staff member had failed to complete the documentation. Resident #022 had been given a bed bath, not a shower as outlined in the resident plan of care. The PSW was unable to provide a reason for not giving resident #022 a shower and also failed to document that the care had been provided.

A critical incident was submitted by the home, notifications were made in accordance with the legislated requirements and follow up with the staff involved was taken in regards to the late reporting of these alleged incidents of staff to resident neglect. The home was able to provide evidence that the RPN and the PSW's involved had all received abuse training in 2017.

ADOC #124 was interviewed in regards to the expectations of reviewing the resident twenty four hour progress notes. The ADOC indicated it is the expectation that the RN's review the notes or obtain the pertinent information during the shifts for which they are in charge and to follow up as required. She further stated the ADOC's and DOC do try to review the twenty four hour progress notes when time allows but that the notes are not reviewed daily.

The Administrator was interviewed in regards to the failure of the home to immediately investigate and report the alleged incidents of neglect. The Administrator confirmed the notes in point click care are accessible from home for the managers on call. She stated the RN's are to review the twenty four hour notes when coming onto shift and are to monitor for reporting omissions or issues that require follow up. The Administrator also stated the ADOC's and DOC are to review the twenty four hour notes during the week days to ensure reportable incidents are not overlooked.

During this inspection, the licensee has also failed to comply with the following:

LTCHA, s. 23 (1)-failing to immediately inspect two incidents of alleged staff to resident neglect and one incident whereby unclear details related to a possible incident involving resident #001 were not immediately investigated by the home;
LTCHA, s. 20 (1)-failing to ensure the written policy to promote zero tolerance of abuse was complied with whereby two alleged incidents of staff to resident neglect were reported to RPN #129 and the RPN failed to ensure these incidents were immediately reported to the manager on duty;
LTCHA, s. 24 (1)-failing to ensure a person who had reasonable grounds to suspect that two incidents of staff to resident neglect had occurred, involving resident #001 and #002, immediately reported the incident to the Director (MOHLTC).

The scope was assessed to be a pattern. Two out of two alleged incidents of staff to resident neglect inspected were never investigated or reported in accordance with the home's abuse policy. one incident, where potential resident harm was yet to be determined, was not immediately investigated and two incidents of suspected staff to resident neglect were not immediately reported to the managers in the home.

The severity was assessed as being actual harm. Resident #001 reported being frightened related to the incident involving the tub bath, and reported discomfort and anger as a result of being left on the commode for more than an hour. Resident #002 was documented as being unsteady/leaning following the incident of being left on the commode and was at risk of falling.

The home's compliance history over the past three years was reviewed and was as follows:
November 8, 2017: 1 written notification (WN) was issued under LTCHA, 2007, s. 24 (immediately reporting alleged abuse/neglect to the Director),
January 27, 2016: 1 WN and 1 voluntary plan of correction (VPC) was issued under LTCHA, 2007, s. 20 (abuse policy),
June 15, 2015: 1 WN and 1 Compliance order was issued under LTCHA, 2007, s. 19 (duty to protect).
Upon taking of all these factors into account, a Compliance order will be issued. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 following findings relates to Log #026101-17:

The licensee has failed to ensure the protocol related to safety checks of residents and developed under the required program for fall prevention was complied with.

O. Reg 79/10, s.49 (1) indicates the licensee is to provide for strategies to reduce or mitigate falls, including the monitoring of residents.

The home has a written protocol that directs all Registered staff and Personal Support Workers to complete hourly checks on all assigned residents to ensure resident safety.

ADOC #124 provided this inspector with a copy of the day, evening and night shift routines for both the Registered staff and the PSW's and indicated the duties were revised as of December 14, 2017.

The ADOC stated there has always been an expectation that all staff (registered and non-registered) complete safety checks on the residents at the beginning of the shift, hourly throughout the shift and prior to reporting off duty. The ADOC indicated the updated protocol now includes the assigning of one PSW to monitor the halls during the day and evening report. This was implemented to respond to any call bells that may be activated during report time.

As outlined in WN #1, staff failed to complete hourly safety checks for residents #001 and #002. [s. 8. (1)]

2. The licensee has failed to ensure the written policy, "Mechanical Lifts Procedure",

#LP-01-01-03, developed under the required program for fall prevention was complied with.

O.Reg 79/10, s. 49 (1) indicates the licensee must provide strategies to reduce or mitigate falls including the use of equipment, supplies, devices and assistive aids.

The home's written policy titled, "Mechanical Lifts Procedure", #LP-01-01-03 to ensure the safe transfer of residents was reviewed. This policy indicated under "Pre-transfer Procedure",
-gather the appropriate sling identified on the care plan and ensure it is the correct size, correct type and correct supplier.
-complete a pre-transfer review for resident readiness, staff readiness, environmental readiness and equipment readiness. If any deficiencies are identified or suspected, do no proceed with the transfer and notify the supervisor.

On the identified date, resident #001 was being assisted by PSW #126 to have a tub bath. The resident was sitting in the sling during the bath when one of the leg straps of the sling became detached from the lift. The resident began to turn sideways in the tub. The PSW activated the emergency alarm and additional PSW staff came to assist by replacing the sling and assisting the resident out of the tub. The resident was documented as having expressed fear related to the incident throughout the two shifts that followed.

The PSW who was present during the incident was interviewed by the home and stated she had been unable to find a hygiene sling to use during resident #001's tub bath and therefore a regular sling was used. The PSW stated that while the resident was seated in the tub, one leg strap disconnected from the lift because the clip was "worn".

ADOC #124 was interviewed and stated the home expects staff to utilize hygiene slings for tub bathing as a regular sling does not have an opening to facilitate proper perineum care/hygiene. The ADOC stated all staff are to visually inspect all slings prior to each use to ensure they are in good condition. The ADOC stated the PSW had failed to use the correct sling and to inspect the sling prior to its use. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure safety checks are completed on all residents in accordance with the Registered staff and Personal Support worker protocol and to ensure the policy, "Mechanical lifts Procedure", #LP-01-01-01 is complied with for all residents that utilize a mechanical lft, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following findings relates to Log #026101-17:

The licensee has failed to ensure resident #001, #002 and #022's plans of care were provided as specified in the plans.

As outlined in WN #1, resident #002 was not toiletted in accordance with the plan of care in effect at the time of the incident.

Resident #002's plan of care was reviewed and indicated the following:

Under "ADL-toilet" the plan indicated the resident performs some aspects of the toilet process with extensive assistance of staff.
-staff provide weight bearing assistance during toileting; resident holds onto the bars in the washroom to steady while staff assist.

Under "Falls" the plan indicated the resident has been assessed as a high risk of falls related to poor balance,
- a chair alarm is placed on the resident walker for safety to notify staff when attempts to

wander away from walker.

Staff were interviewed and indicated the resident is not left unattended on the toilet as the resident is at risk of falling and due to the resident's level of cognition, the resident is unaware of their limitations. [s. 6. (7)]

2. As outlined in WN #1, resident #001 was not toiletted in accordance with the plan of care in effect at the time of the incident.

Resident #001's plan of care related to toileting was reviewed. Under "ADL-toilet" the plan indicated the following:
-resident is safe to leave unattended on the toilet
-staff give call bell and check frequently
-resident uses a sling lift for toileting with extensive assist of two staff.

Additionally, as outlined in WN #1, resident #001was given a tub bath using a regular sling. According to ADOC #124, residents are to be bathed using hygiene slings to facilitate proper peri care. [s. 6. (7)]

3. The following finding relates to Log #028931-17:

As outlined in WN #1, resident #002 was given a bed bath on the identified date. When the PSW was interviewed in regards to why the resident was given a bed bath and not a shower as indicated in the plan of care, the PSW was unable to provide a reason.

Resident #022's plan of care was reviewed and indicated the following:

Under "Bathing" the plan indicated resident prefers a shower.

The staff failed to provide care to residents #001, #002 and #022 as specified in the plan. [s. 6. (7)]

WN #4: 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 ensure all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

On November 24 and 27, 2017, this inspector conducted a full walking tour of all resident home areas. Each floor has two linen closets that are located on each resident wing ("B" and "C" sides). The linen closets on all four floors were found to be unlocked and at the time of the tours, no staff were found in the vicinity of the linen closets. Medicated ointments were found to be stored with the linens on each of the resident wings with the exception of the first floor and the third floor, "B" side.

On December 18, 2017, this inspector conducted a full walking tour of all resident home areas and noted all linen closets had swipe mechanisms now installed and the doors were found to be closed and locked.

On December 19, 2017, on or about 1000 hour, this inspector noted the linen closet on Crestview (second floor), side "B" was ajar as well as the shower room door located across from the centre core sitting area. At the time of the observations, there were no staff in these areas, but several residents were seated adjacent to the shower room door.

Staff were interviewed in regards to the linen closets and indicated the doors were to be locked at all times when not in use. RPN #117 indicated the shower door (equipped with a push code entry) was known to stick and would not fully close and lock unless pushed shut.

ADOC #124 confirmed that the linen closets and the shower room on Crestview were considered non-residential areas and that the doors should be closed and locked at all times when staff are not in the area. [s. 9. (1) 2.]

WN #5: 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 following finding relates to Log #026101-17:

The licensee has failed to ensure that the resident to staff communication response system was accessible at all times for resident #001.

As outlined in WN #1, resident #001 did not have access to the call bell system on the identified date when they were seated on the commode. The resident progress notes were reviewed and indicated the resident was left on the commode and not found until 1555 hour. The resident was interviewed and stated they were there for over one hour and was unable to ring for assistance as the call bell was not within reach. [s. 17. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following finding relates to Log #028931-17:

The licensee has failed to ensure the home's zero tolerance of abuse and neglect policy was complied with.

As outlined in WN #1, suspected incidents of staff to resident neglect involving resident #021 and #022 were not immediately reported to the manager by RPN #129 as outlined in the home's abuse policy.

The home's abuse policy, "Zero tolerance of Resident Abuse and Neglect", #RC-02-01-01 was reviewed. Under "Procedures" the following was stated:
-any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time.

RPN #129 failed to immediately report the alleged incidents of resident neglect to the reporting manager upon being made aware of the allegations from PSW #128.

The home was able to provide documentation to support the staff members involved had received abuse training in 2017. [s. 20. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The following findings relates to Log #026101-17:

The licensee failed to immediately investigate an alleged incident of staff to resident neglect involving resident #002.

As outlined in WN #1, resident #002 was found on the identified date on or about 1645 hour on the toilet in the shower room. The resident had been toileted by the day staff but staff failed to communicate this to the oncoming shift. Staff were directed to look for the resident by RPN #117 and the resident was found on the toilet located inside a locked shower room at 1645 hour.

ADOC #123 was interviewed and confirmed she was the manager on call and recalled being made aware of the incident involving resident #002. The ADOC indicated she was told the resident was found in the bathroom across from the locked shower room and did not find this to be unusual for this resident. No investigation was completed in regards to the length of time the resident was left unchecked by staff and no further action was taken by the home. The ADOC indicated she did not read the progress notes made by RPN #117 that gave details of the incident and the location where resident #002 was found. [s. 23. (1) (a)]

2. The licensee failed to immediately investigate an alleged incident of staff to resident neglect involving resident #001.

As outlined in WN #1, resident #001 was found on the commode, without access to the call bell on an identified date. The resident was interviewed and stated they recalled the incident and that they were very upset. Resident #001 stated they were on the commode for over an hour and were unable to call for assistance because they could not reach the call bell. The resident stated it was uncomfortable being left for that length of time and pointed to the commode stating, "it isn't very comfortable as you can see."

RPN #125 documented in the resident progress notes that she notified RN #108 regarding this incident. The RN stated ADOC #123 was notified at the time of the incident. ADOC #123 was interviewed and stated she had no notes to reflect the notification of this call. The Administrator was interviewed and confirmed no further investigation had been completed and no actions had been taken by the home to address this incident. The Administrator was aware the incidents involving resident #001 and #002 were both documented in the progress notes and unsure why the RN's or the ADOC's had not noted the entries during their review of the twenty four hour notes. [s. 23. (1) (a)]

3. The home also failed to immediately investigate an incident involving resident #001 whereby the on call manager had unclear details of another incident.

As outlined in WN #1, resident #001 was being assisted by PSW #126 to have a tub bath on a specified date.

RPN #119 was working on the resident unit on that evening and was interviewed. She indicated the PSW staff did not report the incident to her until the end of the shift. The RPN stated she reported the incident to RN #127 who was in charge of that resident unit. A late entry progress note was made by RPN #119 on the following day at 1459 hour.

RN #127 was interviewed and stated she was unaware this incident had occurred until she was asked by ADOC #124 to interview the RPN and the PSW's that worked on the evening shift about this incident.

ADOC #124 stated she was the on call manager for the identified weekend. She stated she became aware that something had occurred involving resident #001 the following morning at approximately 0800 hour. The ADOC stated there had been no documentation in the progress notes to reflect any incident and the ADOC did not know if the resident had fallen or any details of the incident. The inspector noted during a review

of the resident progress notes that the night shift and day shift following this alleged incident had both documented entries that reflected the resident was expressing fear related to the incident the previous evening.

The ADOC was asked what actions were taken in regards to hearing this information and she stated she asked RN #127 to interview the staff when she came onto shift at 1500 hour. The one email given to the inspector outlined the results of the interview with staff. The second email was sent by ADOC #124 to ADOC #123 at 1602 hour. The email stated the clip on the resident's sling was worn and that the resident did not go under the water and was safe.

The ADOC indicated upon completion of the investigation and interviews she concluded the incident was not reportable.

The licensee failed to immediately investigate the above incidents involving residents #001 and #002. [s. 23. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The following finding relates to Log #026101-17:

The licensee has failed to ensure an alleged incident of staff to resident neglect was immediately reported to the Director (MOHLTC).

As outlined in WN #1, on the identified date, resident #002 was left unattended on the toilet in the shower room and not found until 1654 hour.

The RPN indicated that after assessing the resident, she notified ADOC #123 about the incident. The RPN stated she felt this was a possible incident of resident neglect as she assumed the resident had been placed on the toilet by day staff and forgotten there. The RPN stated the day shift had not communicated to the evening shift that resident #002 was on the toilet. Additionally, the RPN stated the staff on evenings had not completed their safety checks of the resident which led to the delay in finding resident #002.

The RPN indicated ADOC #123 told her the incident was not reportable because resident #002 did not sustain any injuries. The ADOC further indicated to the RPN that the incident would be dealt with internally.

ADOC #123 was interviewed and stated she did receive notification of the incident involving resident #002. The ADOC stated she was told the resident was found in the bathroom across from the shower room and did not think this was unusual as the resident was able to toilet herself. The ADOC indicated she was told the resident was not harmed and therefore the incident was not reportable. The ADOC stated she told the RPN to be sure the staff were completing their hourly checks on the residents and that she reported this incident the following morning to the Administrator as the ADOC was beginning holidays.

The Administrator was interviewed and stated she recalled being told about this incident by ADOC #123 but no further action was taken. The Administrator stated she was told the resident was found in the bathroom across from the locked shower room and was told this was not unusual for this resident. The inspector indicated the notes in point click care supported the finding of the resident in the shower room. The Administrator confirmed the notes in point click care are accessible from home for the managers on call and that the Registered Nurses are supposed to be reviewing the twenty four hour notes each shift. The Administrator indicated there were no investigation notes related to the incident and no further actions taken. [s. 24. (1)]

2. The licensee has failed to ensure an alleged incident of staff to resident neglect involving resident #001 was immediately reported to the Director (MOHLTC).

As outlined in WN #1, on an identified date, resident #001 was found on the commode at 1555 hour by the evening staff. According to the progress notes, the resident's call bell was not within reach, the resident was "very upset" and the resident's buttocks and thighs were found to be reddened.

The PSW reported the incident to RPN #125 who in turn notified RN #108 who was in charge at the time. RPN #125 was unavailable for interview. RN #108 was interviewed and stated she recalled the incident and that she had notified ADOC #123. The RN indicated she did believe the incident to be neglectful because the resident did not have access to the call bell and was forced to stay on the commode until staff found them. The RN indicated the ADOC stated "not to worry about it" and she would follow up with staff on Monday (the following day). The RN stated she did not hear anything further from management in regards to the incident.

ADOC #123 was interviewed and confirmed she was the on call manager on the identified date. She stated she had no recall of the event and after reviewing her notes stated she had no documentation in regards to this incident. The ADOC stated the resident frequently requests to be put on the commode and did not think that would make it an incident of neglect. The inspector reminded the ADOC that the resident did not have access to the call bell during this incident and the resident expressed dissatisfaction with the staff when found. The ADOC stated she was unsure why there was no follow up or further investigation into the incident.

The Administrator was interviewed and was unaware of the incident. The inspector stated the progress notes had reflected the incident and the notifications made and included the entries whereby the resident expressed upset with the staff. She stated there should have been immediate follow up to determine the facts and to follow up with the staff in regards to the call bell and alleged staff to resident neglect. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The following finding relates to Log #026101-17:

The licensee has failed to ensure a sufficient supply of clean face cloths, and bath towels are always available in the home for the use by residents.

PSW staff were interviewed in regards to the availability and sufficiency of linens for the residents. PSW #103 indicated she works primarily on the secure unit and stated that the home runs short of sufficient face cloths on a regular basis. The PSW indicated she would estimate on five to six days out of seven, she has had to use hand towels to care for the residents because the unit has run out of face cloths. The PSW stated the staff are told additional cloths have been put into circulation, but she does not feel the amount has been sufficient to rectify the problem.

PSW #102 indicated she works on a variety of floors and that it is common to run out of facecloths before all of the morning care is completed. The PSW stated the facecloths are insufficient on six out of seven shifts that she works. She stated the linens are delivered to the floor around 1100 hour and again in the late afternoon. The PSW stated that on the days when she runs out of facecloths, she utilizes hand towels to finish resident care.

PSW #105 was interviewed in regards to the availability of resident linens. The PSW stated that on the secure unit the linen cupboards were locked and the only two staff members that had keys to unlock these areas were the housekeeper and the RPN. The PSW stated on one occasion resident #003 had been incontinent of stool. Both the RPN and the housekeeping staff were off the floor on a break and unavailable to unlock the linen closets. The PSW stated staff went from room to room trying to locate linens to provide resident #003 with the care required. The PSW stated the staff were unable to find additional linens and had to utilize the resident's sheets, pillow case and blanket to clean the resident. The PSW stated this is not an isolated incident.

On December 18, 2017, the inspector noted all linen closets were now equipped with swipe card access. The PSW staff were interviewed and indicated they have all been provided with a swipe card to access these linen closets.

The inspector conducted a full walking tour of the resident care units on November 24, 27 and December 19, 2017. On December 19, 2017, on or about 0930 hour, the first floor was found to have a total of 27 facecloths available for both sides and the PSW staff reported there were several residents who still required morning care. PSW #105 stated that during a day shift the previous week, the staff had completely run out of face cloths before the completion of morning care. The fourth floor had a total of nine facecloths available and PSW #116 stated several residents still required morning care. Both PSW's stated the amount of face cloths available is dependent on the amount that is required on the night shift.

The Environmental Services Supervisor #110 was interviewed and stated laundry is delivered to each floor around 1100 hour and again around the supper hour. #110 was able to show this inspector that additional supplies of facecloths are put into circulation on a regular basis. #110 stated the department had completed a week long audit in May 2017 which indicated the loss of more than one thousand facecloths over the period of one week. #110 stated the home continues to replenish the linen supplies (especially face cloths) for each floor on a monthly basis.

The home has failed to ensure a sufficient supply of face cloths is always available for use by residents. [s. 89. (1) (b)]

WN #10: 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 following finding relates to Log #026101-17:

The licensee has failed to ensure medicated topicals were stored in an area that was kept locked at all times when not in use.

On November 27, 2017 on or about 1300 hour, this inspector conducted a tour of all resident units to observe the home's storage practices related to medicated ointments. On floors 2, 3 and 4, medicated ointments were found to be stored in the linen closets that are located on each wing except for floor three on the "B" wing which had none. At the time of the tour, the linen closets were observed to have no locking mechanism except for a sliding lock located at the top of each closet. Each linen closet was found to be unlocked and was able to be opened by this inspector without unsliding the locking mechanism.

The linen closets are located in close proximity to the resident rooms, and at the time of the tour, there were no staff found to be in the vicinity of the linen closets.

The Gardenwalk Terrace (secure unit) was noted to have locking mechanisms on the linen closets. Upon inspection of these two linen closets, medicated ointments were not found.

On December 18, 2017, this inspector observed that the home had installed swipes on each of the four resident unit linen closets. Each staff member has a fob that can be utilized to access the area. [s. 130. 1.]

Issued on this 11th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2017_505103_0052
Log No. / No de registre :	026101-17, 028931-17, 029199-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 11, 2018
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 :	Casie Keyes

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 : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to ensure residents are protected from incidents of neglect by implementing the following:

-the development and implementation of a monitoring process to ensure the person who has reasonable grounds to suspect the neglect of a resident that resulted in harm or risk of harm is immediately investigated,
-the development and implementation of a monitoring process to ensure the person who has reasonable grounds to suspect the neglect of a resident that resulted in harm or risk of harm is immediately reported to the Director,
-the development and implementation of specific measures to be in place when the home's abuse policy is not complied with,
-a process whereby the Director of Care and/or a specified designate is reviewing all communication from staff at least daily to determine if there are entries to identify any potential unreported incidences of resident abuse or neglect,
-a process to assess the knowledge and skills of all staff and managers in relation to the implementation of the home's zero tolerance of abuse policy.

Grounds / Motifs :

1. The licensee has failed to ensure residents #001, #002, #021, and #022 were protected from incidents of alleged staff to resident neglect.

The Long Term Care Home Act, 2007, defines resident neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The following findings are related to Log #026101-17:

Resident #002 was admitted to the home in an identified year and had identified diagnoses. On a specified date, on or about 1600 hour, RPN #117 was administering medications and noted that she was unable to locate resident #002. The staff were asked to look for the resident and found the resident seated on the toilet in the shower room at approximately 1645 hour. The resident was noted to be leaning to the right and had no brief on. Three PSW's assisted the resident to stand and provided resident #002 with care. The resident was noted to have redness on the buttocks area from the toilet seat and was unsteady when ambulated.

RPN #117 was interviewed and stated none of the staff, including herself, had seen resident #002 since their arrival on shift at 1500 hour. The RPN stated the resident was usually either in their room or in the centre core seating area. The RPN was asked to show this inspector where the resident was found. The RPN took the inspector to the shower room located across from the centre core seating area and indicated this room also has a toilet. The door was noted to have a push code access and the RPN confirmed this door was to be closed and locked at all times.

The RPN stated she felt this was a possible incident of resident neglect as she assumed the resident had been placed on the toilet by day staff and forgotten there. The RPN stated the day shift had not communicated to the evening shift that resident #002 was on the toilet. Additionally, the RPN stated the staff on evenings had not completed their safety checks of the resident which led to the delay in finding resident #002. RPN #117 indicated after assessing the resident, she notified ADOC #123 of the incident. The RPN stated the ADOC directed her to ensure the staff were completing their safety checks and that the incident would be managed internally. RPN #117 documented the details of the incident in the resident progress notes which included where the resident was found.

ADOC #123 was interviewed and confirmed she was the manager on call and recalled being made aware of the incident involving resident #002. The ADOC was asked to describe the investigation that was completed in response to this incident. The ADOC stated she was told by RPN #117 the resident had been found in the bathroom across from the shower room, not the locked shower room. She stated she believed the resident had toileted themself and therefore did not further investigate the incident. The ADOC stated she asked to have the

resident assessed for injuries and told the RPN to ensure staff were completing hourly checks.

The Administrator was interviewed and stated she recalled being told about this incident by ADOC #123 the following morning, but no further action was taken. The Administrator stated she was told the resident was found in the bathroom across from the locked shower room and was told this was not unusual for this resident, therefore, no further investigation was completed. The inspector indicated the notes in point click care supported the finding of the resident in the shower room and questioned if there were any concerns related to the length of time the resident went unchecked. The Administrator agreed further investigation should have been done based on the fact the resident had not been checked during the first two hours of the shift. To date of this inspection, a critical incident was not been submitted by the home and notifications to the Ministry of Heath and Long Term Care (MOHLTC) or the family were not made related to the alleged staff to resident neglect.

Resident #001 was admitted to the home in an identified year and had identified diagnoses. On a specified date, resident #001 was being assisted by PSW #126 to have a tub bath. The resident was sitting in the sling during the bath when one of the leg straps of the sling became detached from the lift. The resident began to turn sideways in the tub. The PSW activated the emergency alarm and additional PSW staff came to assist by replacing the sling and assisting the resident out of the tub. The resident was documented as having expressed fear related to the incident throughout the two shifts that followed.

The resident was interviewed and could not recall all of the details, but indicated they remembered turning sideways in the tub and believed this happened because the sling had not been properly applied. Resident #001 stated the incident had frightened them.

RPN #119 was interviewed and stated the PSW staff did not report the incident to her until the end of the evening shift. According to the RPN, she notified RN #127 of the incident at that time. RN #127 was interviewed and stated she was not made aware of the incident until the following day when she reported for work on the evening shift. The RN indicated ADOC #124 had asked her to interview the staff that had worked the previous evening to get the details of the incident.

ADOC #124 was interviewed and stated she was the on call manager on the identified dates. She stated she became aware that something had occurred involving resident #001 on the following morning at approximately 0800 hour. The ADOC was asked to provide any investigation notes related to this incident and gave the inspector two emails. According to the ADOC, she had heard rumours that morning that something had occurred involving resident #001 on the previous evening and that it involved a sling and the resident having a tub bath. The ADOC stated there had been no documentation in the progress notes to reflect any incident and the ADOC did not know if the resident had fallen or any additional details of the incident.

The ADOC was asked what actions were taken in regards to hearing this information and she stated she asked RN #127 to interview the staff when she came onto shift later that day at 1500 hour. The one email given to the inspector outlined the results of the interview with staff. The second email was sent by ADOC #124 to ADOC #123 following the interviews at 1602 hour. The email stated the clip on the resident's sling was worn and that the resident did not go under the water and was safe.

ADOC #124 delayed investigating the incident for approximately seven hours after being made aware that an incident involving resident #001 had occurred the previous evening. ADOC #124 indicated upon completion of the interviews with the staff, she did not feel the incident was reportable but was unable to make that determination until after the investigation was completed.

On another specified date, resident #001 was found on the commode at 1555 hour by the evening staff. According to the progress notes, the resident's call bell was not within reach, the resident was "very upset" and the resident's buttocks and thighs were found to be reddened. The resident was interviewed and stated they had been left on the commode for more than an hour and was unable to call for assistance because they could not reach the call bell. The resident stated it was uncomfortable being left for that length of time and pointed to the commode stating, "it isn't very comfortable as you can see."

RPN #125 documented in the resident progress notes that she notified RN #108 regarding this incident. The RPN was not available for interview. RN #108 was interviewed and confirmed she was advised of this incident. The RN stated she believed the incident constituted resident neglect because the resident did not have access to the call bell. The RN stated she recalled the on call manager

was ADOC #123. The RN stated the ADOC had told her "not to worry about it" and that the ADOC would follow up Monday (the following day). The RN stated she did not hear anything further in regards to this incident

ADOC #123 was interviewed and stated she had no notes to reflect the notification of this call. The Administrator was interviewed and confirmed no further investigation had been completed and no actions had been taken by the home to address this incident. To date of this inspection, a critical incident has not been submitted by the home and notifications to the MOHLTC or the family were not made in regards to either incidents involving resident #001.

The following finding relates to Log #028931-17:

On a specified date, PSW #128 had observed residents #021 and #022 fully dressed at 0740 hour. The PSW asked PSW's #130 and #105 if both residents had already been bathed and the PSW's indicated they had.

PSW #128 reported to RPN #129 that she suspected PSW's #130 and #105 had not provided personal care to residents #021 and #022 as outlined in their plan of care. No further action was taken by RPN #129 in regards to this alleged staff to resident neglect.

ADOC #124 was interviewed and stated PSW #128 brought the issue forward to management on the following morning as she believed there had been no follow up the previous day. The ADOC indicated the home began to investigate the allegation immediately. During the investigation it was reported that resident #021 had been bathed, but the staff member had failed to complete the documentation. Resident #022 had been given a bed bath, not a shower as outlined in the resident plan of care. The PSW was unable to provide a reason for not giving resident #022 a shower and also failed to document that the care had been provided.

A critical incident was submitted by the home, notifications were made in accordance with the legislated requirements and follow up with the staff involved was taken in regards to the late reporting of these alleged incidents of staff to resident neglect. The home was able to provide evidence that the RPN and the PSW's involved had all received abuse training in 2017.

ADOC #124 was interviewed in regards to the expectations of reviewing the

resident twenty four hour progress notes. The ADOC indicated it is the expectation that the RN's review the notes or obtain the pertinent information during the shifts for which they are in charge and to follow up as required. She further stated the ADOC's and DOC do try to review the twenty four hour progress notes when time allows but that the notes are not reviewed daily.

The Administrator was interviewed in regards to the failure of the home to immediately investigate and report the alleged incidents of neglect. The Administrator confirmed the notes in point click care are accessible from home for the managers on call. She stated the RN's are to review the twenty four hour notes when coming onto shift and are to monitor for reporting omissions or issues that require follow up. The Administrator also stated the ADOC's and DOC are to review the twenty four hour notes during the week days to ensure reportable incidents are not overlooked.

During this inspection, the licensee has also failed to comply with the following:

LTCHA, s. 23 (1)-failing to immediately inspect two incidents of alleged staff to resident neglect and one incident whereby unclear details related to a possible incident involving resident #001 were not immediately investigated by the home;
LTCHA, s. 20 (1)-failing to ensure the written policy to promote zero tolerance of abuse was complied with whereby two alleged incidents of staff to resident neglect were reported to RPN #129 and the RPN failed to ensure these incidents were immediately reported to the manager on duty;
LTCHA, s. 24 (1)-failing to ensure a person who had reasonable grounds to suspect that two incidents of staff to resident neglect had occurred, involving resident #001 and #002, immediately reported the incident to the Director (MOHLTC).

The scope was assessed to be a pattern. Two out of two alleged incidents of staff to resident neglect inspected were never investigated or reported in accordance with the home's abuse policy. one incident, where potential resident harm was yet to be determined, was not immediately investigated and two incidents of suspected staff to resident neglect were not immediately reported to the managers in the home.

The severity was assessed as being actual harm. Resident #001 reported being frightened related to the incident involving the tub bath, and reported discomfort and anger as a result of being left on the commode for more than an hour.

Resident #002 was documented as being unsteady/leaning following the incident of being left on the commode and was at risk of falling.

The home's compliance history over the past three years was reviewed and was as follows:
November 8, 2017: 1 written notification (WN) was issued under LTCHA, 2007, s. 24 (immediately reporting alleged abuse/neglect to the Director),
January 27, 2016: 1 WN and 1 voluntary plan of correction (VPC) was issued under LTCHA, 2007, s. 20 (abuse policy),
June 15, 2015: 1 WN and 1 Compliance order was issued under LTCHA, 2007, s. 19 (duty to protect).
Upon taking of all these factors into account, a Compliance order will be issued. [s. 19. (1)]

(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 14, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 11th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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