Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Sep 25, 2017	2017_370649_0014	013266-17	Resident Quality Inspection

Licensee/Titulaire de permis

ATK CARE INC.
1386 INDIAN GROVE MISSISSAUGA ON L5H 2S6

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

RIVER GLEN HAVEN NURSING HOME
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

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

JULIEANN HING (649), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, August 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, and 23, 2017.

The following Critical Incidents and complaints were inspected concurrently with this Resident Quality Inspection:
Log #009341-17, 009877-17, 012994-17 related to abuse
Log #017202-16 related to Responsive Behaviours
Log #017818-17 related to Reporting
Log #017824-17, 005185-17 related to Staff to Resident Abuse

The following Complaints were inspected concurrently with this Resident Quality Inspection:
Log #031830-16 related to Resident Care
013537-17 related to Plan of Care
016256-17 related to Funding

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Recreation Director, Director of Support Services (DSS), Behavioural Support Resource Team Lead (BSRTL), Resident Assessment Instrument (RAI) Co-ordinator, Environmental Service Manager (ESM), Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist Assistants (PTAs), Nursing Admin Assistant, Geriatric and Neuropsychiatry Outreach Services from Ontario Shores (GNOS), Dietary Aides (DAs), Substitute Decision Makers (SDMs), and residents.

During the course of the inspection, the Inspectors observed staff to resident interactions, reviewed relevant policies, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **21 WN(s)**
- **12 VPC(s)**
- **6 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_626501_0004	501
O.Reg 79/10 s. 49. (2)	CO #002	2016_353589_0019	649
O.Reg 79/10 s. 69.	CO #003	2016_353589_0019	501
O.Reg 79/10 s. 8. (1)	CO #004	2016_353589_0019	501

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Record review of Critical Incident Report (CIR) submitted to the Ministry of Health and Long-Term Care (MOHLTC) in March 2017, indicated resident #013 was observed to have an significant injury. Further review of the CIR indicated that resident #013 reported that he/she heard people on the roof last night and used the call bell to call for help. The

resident reported that he/she did not want to let go of the call bell and was wrestling with two staff for it.

A review of resident #013 progress notes indicated frequent incidents of responsive behaviours.

Interview with Personal Support Worker (PSW) #151 revealed that resident #013 exhibited the responsive behaviour for the entire night shift. The PSW further stated that this behaviour occurs frequently and PSW #151 and #144 revealed that they will reorient the resident from time to time, and provide reassurance. According to PSW #151, if the resident becomes agitated and exhibits another identified behaviour he/she would let the registered nurse know. The resident will settle and go to sleep after the registered staff administers prescribed medication.

Interview with Behavioural Support Resource Team Lead (BSRTL) revealed that resident #013 has a history of a responsive behaviour and would require an assessment if the identified behaviour was distressing to the resident and indicated that no assessment had been completed. BSRTL further revealed that the identified behaviour and strategies had not been incorporated in the resident's plan of care.

Interview with the Registered Practical Nurse (RPN) #111 revealed that resident #013 exhibits the specific responsive behaviour almost daily at the same time. The resident has been exhibiting this behaviour for approximately 10 months and this had not been incorporated into the resident's written plan of care plan.

Interview with the Assistant Director of Care (ADOC) revealed that resident #013 was exhibiting specific responsive behaviours mostly at the same time of day. The ADOC and the Administrator revealed that the specific responsive behaviour and strategies had not been incorporated into the resident's written plan of care. [s. 6. (1)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #005 triggered for a fall incident within the last 30 days from stage one of the Resident Quality Inspection (RQI). Review of the resident's progress notes revealed resident #005 had a fall in June 2017, and sustained an injury. According to this progress note, RPN #118 spoke with the charge nurse about the possibility of implementing a fall

prevention device for the resident's bed and chair.

Interview with RPN #118 revealed he/she could not recall if he/she spoke with the charge nurse about the fall prevention device but thinks he/she spoke with the full-time RPN #137. Interview with RN #138 who was scheduled as the charge nurse on this shift when the above mentioned incident occurred, did not recall anything and does not recall conducting a post fall meeting. Interview with RPN #137 did not recall being informed about implementing a fall prevention device for resident #005 but did agree the resident would benefit from this.

Interview with the Director of Care (DOC) revealed that the home has had trouble following their new policy to have an immediate interdisciplinary post-fall meeting. Interview with RPN #137 revealed the process to have post-fall meetings is new and the staff are just getting used to this.

Due to the staff failing to hold a post fall meeting and failing to relay information regarding the implementation of a fall prevention device for resident #005, the home did not ensure staff involved in the resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

Resident #002 triggered from stage one of the RQI for eating decline since admission. Record review revealed resident #002 was admitted to the home in December 2016, and according to the MDS assessment the resident leaves a certain percentage of food uneaten at most meals.

Review of resident #002's most recent plan of care revealed the resident has been assessed to require a special diet including fluid restrictions. According to his/her dietary restrictions posted in the home, which included whole wheat breads be limited and only an identified amount of fluids offered at lunch.

Observation on July 21, 2017, during a meal revealed resident #002 was provided with identified amounts of fluids as well as a whole wheat bun as part of his/her entrée. The resident partially consumed the whole wheat bun and did not consume all the fluids.

Interview with the Dietary Aide (DA) #126 revealed he/she did not have any white bread rolls and he/she needed to review the dietary restrictions. Interview with PSW #116 who served the fluids revealed he/she was unsure about resident #002's fluid restriction. According to RPN #131, resident #002 is served several fluids because he/she has poor fluid consumption and they watch and monitor to see what he/she will consume.

Observation on July 22, 2017, during lunch revealed resident #002 was not offered soup. Interview with PSW #130 revealed he/she did not offer resident #002 soup because he/she thought resident #002 was on a fluid restriction.

Interview with the Director of Support Services (DSS) and the Registered Dietitian (RD) revealed resident #002 should not have been served a whole wheat bun and should have only been served the identified amount of fluids on July 21, 2017. Interview with the RD revealed resident #002 should be offered the identified fluid type as long as his/her total fluid consumption did not exceed an identified amount.

Interview with the DSS and the RD confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan on the above mentioned days. [s. 6. (7)]

4. CIR was submitted to the MOHLTC in May 2017, related to inappropriate touching. According to the CIR, PSW #106 observed resident #011 and #010 inappropriately touching in a public area of the home. Resident #011 was noted to be restless that day due to a medical condition which prohibited him/her from leaving him/her room. Both residents were distracted by staff and resident #010 was easily redirected.

Interview with PSW #106 revealed he/she observed resident #010 in an area of the home near to resident #011's room. Resident #010 was observed to touch resident #011. When PSW #106 attempted to distract resident #010 he/she touched resident #011 before walking away. According to the PSW, resident #010 is most active at identified times when staff are busy tending to other residents in their rooms.

Review of resident #010's plan of care revealed there is a focus for responsive behaviours related to inappropriately touching other residents. The intervention is to check the resident at intervals during certain times and to keep the resident occupied with an activity.

Interview with BSRTL revealed resident #010 exhibited a decline in his/her ability to

ambulate along with an alteration in the resident's level of cognitive functioning following adjustments to the resident's medication regime to manage the responsive behaviours. Resident #010 became wheelchair bound for a short time. According to progress notes, resident #010 recovered from these setbacks and was independently mobile again in April 2017.

Progress notes revealed there was a multidisciplinary meeting in May 2017, to discuss the incident of resident #010 and #011's inappropriate touching. Documentation revealed the purpose of the meeting was to remind staff of distractions that are in place for resident #010 which included assisting with an activity.

Interview with the BSRTL confirmed that the home had lost sight of interventions to address resident #010’s responsive behaviours and were not consistently implementing the activity after the resident recovered in April 2017. An interview with the DOC confirmed the home failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan. [s. 6. (7)]

5. A complaint was submitted in June 2017, to MOHLTC alleging that resident #017 who had returned from hospital on a Thursday with an injury had to wait in bed until the following Monday to be assessed by the Physiotherapist (PT). A second complaint was reported by the Physiotherapist Assistant (PTA) to the MOHLTC inspector in July 2017, alleging that residents who require two staff for therapy may be neglected as there is only one PTA in the home.

Review of resident #017’s written plan of care indicated that he/she was to participate in gait training and ambulation exercises at identified weekly intervals with two staff.

Review of resident #045’s recent plan of care indicated for the resident to receive gait training and ambulation exercises using a walker at identified weekly intervals with two staff.

Review of resident #046’s recent plan of care indicated the resident was to participate in the mobility exercises at identified weekly intervals with two staff.

Interview with the PTA #141 revealed that he/she alone had assisted residents #017, #045, and #046 with ambulation exercises in July and August 2017, and had not followed the residents' plan of care to receive ambulation exercises with two staff.

Interview with the ADOC and DOC revealed that the plan of care for residents' #017, #045 and #046 had not been followed and the PTA should have asked another staff member to assist with the ambulation of the residents. [s. 6. (7)]

6. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it.

Resident #002 triggered from stage one of the RQI for eating decline since admission. Record review revealed resident #002 was admitted to the home in December 2016, and according to the MDS assessment the resident leaves a certain percentage of food uneaten at most meals.

Review of resident #002's most recent plan of care revealed the resident had been assessed to require a special diet including fluid restrictions. According to his/her dietary restrictions posted in the home, indicated whole wheat breads be limited and only an identified amount of fluids offered at lunch.

Observation on July 22, 2017, during lunch revealed resident #002 was not offered soup. Interview with PSW #130 revealed he/she did not offer resident #002 soup because he/she thought resident #002 was on a fluid restriction. Observation revealed resident #002's dietary restrictions with the fluid plan was not available as it had been the day before and PSW #130 was unsure whether resident #002 could be offered soup.

Interview with the DSS revealed that resident #002's diet restrictions should have been available.

Interview with the RD confirmed that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it. [s. 6. (8)]

7. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

On July 14, 2017, at approximately 1025 hours while conducting a narcotic count with RPN #114 on a home area the following were noted:
- Residents #019, #022, #023, and #024's narcotic medications did not match the number of tablets on the medication cards

A review of the home’s policy titled Administering and Documenting Controlled Substances, revision date of November 2015, revealed “the controlled substance medication is initialed as administered, on the Medication Administration Record (MAR), in the correct box, immediately after administration and before the next resident is medicated”.

Interview with RPN #114 revealed that he/she had administered medications to the residents but had not signed the residents' narcotic and controlled substance sheets at the time of administration.

Interview with the Registered Nurse (RN) #115 and DOC revealed when the medication is given the narcotic and controlled count sheet should be signed at the time of administration.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a compliance order (CO) was issued on February 6, 2017, under inspection report #2016_353589_0019 for non-compliance with LTCHA, 2007 S.O. 2007 c.8, s. 6. (7). Due to the severity of potential for actual harm and previous non-compliance with a CO a compliance order is warranted.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it, and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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 licensee has failed to ensure that every alleged, suspected or witnessed abuse of a resident by anyone that the license knows of, or that is reported is immediately investigated.

The home submitted a CIR to the MOHLTC in July 2017, regarding an incident of staff to resident abuse. Review of the CIR revealed resident #033 reported to PSW #150 that PSW #152 provided care to resident #033 in a very rough manner on an identified shift in July 2017.

PSW #150 approached inspectors #649 and #501 in July 2017, regarding the above incident stating on an identified date in July 2017, he/she had reported the incident to RN #113 and provided a written statement. PSW #150 stated he/she was concerned that management had not gotten back to him/her as they usually investigate such matters which would entail interviewing him/her. PSW #150 told inspectors that resident #033 told him/her that PSW #152 was rough with him/her during care because PSW #152 rolled the resident over and grabbed him/her in an a rough manner which made the resident feel concerned. The resident also told PSW #150 that he/she felt nervous for the next time PSW #152 would be providing care.

An interview with the Administrator and DOC in July 2017, revealed the DOC was aware of this incident but had not immediately investigated it because he/she viewed it as a complaint and not an allegation of abuse.

Review of PSW #150's statement that was sent and received by the DOC revealed resident #033 felt as though he/she was treated in a disrespectful way and was nervous for the next time PSW #152 does his/her care.

Interview with RN #133 revealed he/she was informed of the incident by PSW #150 on an identified date in July 2017, and he/she remembered contacting the DOC the same day. The DOC told the RN to obtain a statement from PSW #150 and document his/her own statement of an interview with resident #033 and place these underneath his/her office door.

Further interviews with the DOC were not obtained since he/she was away for medical reasons. Interview with the Administrator revealed that the process in the home is to immediately investigate an allegation of rough handling of a resident because it could be a form of abuse. The Administrator could not explain why this was not immediately investigated and confirmed that the home did not immediately investigate this incident of alleged abuse.

The severity of this non-compliance was identified as actual harm, the scope was

identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on November 16, 2016, under inspection report #2016_321501_0019 for non-compliance with LTCHA, 2007 S.O. 2007 c.8, s. 23. (1) (a). Due to the severity of actual harm and previous non-compliance with a VPC, a compliance order is warranted. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #3: 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 home has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that posed a risk of harm immediately report the suspicion and the information upon which it was based to the Director.

The home submitted a CIR to the MOHLTC in July 2017, regarding an incident of staff to resident abuse. Review of the CIR revealed that resident #033 reported to PSW #150 that PSW #152 provided care to resident #033 in a very rough manner on an identified shift in July 2017.

PSW #150 approached inspectors #649 and #501 in July 2017, regarding the above incident stating on an identified date in July 2017, he/she had reported the incident to RN #113 and had provided a written statement. PSW #150 stated he/she was concerned that management had not gotten back to him/her as they usually investigate such matters which would entail interviewing him/her. PSW #150 told inspectors that resident #033 told him/her that PSW #152 was rough with him/her during care because PSW #152 rolled the resident over and grabbed him/her in a rough manner that caused concern to the resident. The resident also told PSW #150 that he/she felt nervous for the next time PSW #152 would be providing care. In a further interview PSW #150 revealed that resident #033 had also told PSW #151 who worked the shift that the incident occurred.

Interview with PSW #151 revealed that a day or two after the incident resident #033 asked the PSW who was the other PSW that worked with him/her and PSW #151 told the resident it was PSW #152. Resident #033 then told PSW #151 that PSW #152 was very rough. PSW #151 stated he/she reported this to RN #153.

Interview with RN #153 revealed PSW #151 reported that resident #033 reported PSW #152 had been rough with the resident. RN #153 stated he/she left a message on the ADOC's phone and did not call the MOHLTC. Interview with the ADOC revealed he/she did not receive this message until after he/she returned from his/her vacation at which time he/she asked the DOC if he/she was aware of the incident and the DOC responded that he/she was looking after the matter.

Interview with RN #113 revealed he/she did not report the incident to the MOHLTC after PSW #150 reported the incident because he/she had a conversation with RN #153 who stated he/she had already informed the ADOC.

Interview with the Administrator and DOC in July 2017, revealed the DOC was aware of this incident but had not reported it to the MOHLTC because he/she viewed it as a complaint and not an allegation of abuse. According to the home's investigation notes this complaint was submitted to the MOHLTC because inspector #501 requested the DOC to do so despite the fact that the resident who is competent did not identify the actions of PSW #152 as abusive.

Interviews with PSW #150, #151, #152, RN #113, #153 and the Administrator revealed that rough handling may constitute physical abuse as it poses a risk of physical harm to

residents. According to PSW #150, resident #033 was nervous to have PSW #152 care for him/her again because the resident has had a medical condition and did not want to have any further injury.

Interview with resident #033 revealed that PSW #152 had been rough with him/her when rolling him/her in bed as the PSW was pushing him/her too hard and the resident had to hold onto the bed rail. According to resident #033 he/she is unable to roll over on his/her own because he/she has a medical condition. Interview with PSW #152 revealed he/she was aware he/she was doing something wrong because he/she remembers resident #033 saying "ouch".

Interview with the Administrator confirmed the home should have contacted the MOHLTC immediately following the allegation of rough handling which posed the risk of physical harm to resident #033.

The home failed on three occasions to inform the MOHLTC of this incident and even after doing so, did not recognize the severity of the incident and the necessity to report, as evidenced by the DOC's documentation related to the resident downplaying the incident as not being abusive. Further interviews with the DOC were not obtained since he/she was away for medical reasons.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and compliance order (CO) were issued on November 16, 2016, under inspection report #2016_321501_0019 for non-compliance with LTCHA, 2007 S.O. 2007 c.8, s. 24. (1). Due to the severity of potential for actual harm and previous non-compliance with a CO a compliance order is warranted. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #001 triggered from stage one of the RQI for falls prevention. A review of resident #001's written plan of care revealed that the resident is at high risk for falls related to a history of falls with injury, multiple risk factors and non-compliance with mobility aid.

A review of resident #001's falls documented in the progress notes and risk management section revealed the resident fell 17 times during January to June 2017. Further review revealed when the resident fell in April, May and June 2017, no post fall assessment had been completed under the assessment tab in PCC on these dates.

A review of the home's policy titled Fall Prevention and Management #RCSM G-40 dated February 2017, revealed when a resident sustains a fall, a fall assessment is completed under the assessment tab in PCC.

Interviews with the RPN #103, #112, ADOC, and DOC revealed that no post fall assessment had been conducted in PCC under the assessment tab using a clinically appropriate assessment instrument specifically designed for falls when the resident fell in April, May and June 2017. [s. 49. (2)]

2. Resident #003 triggered from stage one of the RQI for fall prevention. A review of resident #003's written plan of care revealed that the resident was at risk for falls related to a history of falls, injury and multiple risk factors.

A review of resident #003's falls documented in the progress notes and risk management section revealed the resident fell 12 times during January to July 2017. Further review revealed when the resident fell in July 2017, no post fall assessment had been completed under the assessment tab in PCC on these dates.

A review of the home's policy titled Fall Prevention and Management #RCSM G-40 dated February 2017, revealed when a resident sustains a fall, a fall assessment is completed under the assessment tab in PCC.

Interviews with the RPN #103, #112, ADOC, and DOC revealed that no post fall assessment had been conducted in PCC under the assessment tab using a clinically appropriate assessment instrument that is specifically designed for falls when the resident fell twice in July 2017.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and compliance order (CO) were issued on February 6, 2017, under inspection report #2016_353589_0019 for non-compliance with the LTCHA, 2007 O. Reg. 79/10, r. 49. (2). Due to the severity of potential for actual harm and previous non-compliance with a CO a compliance order is warranted. [s. 49. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect resident #012 from abuse.

CIR was submitted to the MOHLTC in May 2017, related to resident to resident abuse. The CIR revealed PSW #106 reported, he/she witnessed resident #010 standing on the left side of resident #012 in an area of the home where both residents were participating in a program. Resident #012 was sitting in his/her wheel-chair at the time and facing away from PSW #106. According to the CIR, the PSW observed resident #012 touch resident #010. PSW #106 then called resident #010 out into the hallway who then returned to his/her room. Resident #012 did not sustain any injuries and no ill effects were identified.

Previous inspection report #2016_321501_0019 submitted to the home in November 2016, found resident #010 had abused an identified number of residents from April to September 2016, in an identified number of documented instances, several of which involved resident #012.

Interviews with the BSRTL revealed resident #012 had not been assessed for capacity and consent related to the responsive behaviours. Review of resident #010's plan of care revealed the resident is to be provided constant supervision during programs.

Interview with PSW #106 revealed in May 2017, he/she observed resident #012 exhibiting a responsive behaviour towards resident #010. The PSW separated the residents. According to PSW #106, it is not possible to constantly monitor resident #010 and it is a volunteer that runs the program on identified days with no activity staff in attendance.

Interview with RPN #111 revealed in May 2017, PSW #106 reported that he/she observed resident #010 touch resident #012 during a program. According to RPN #111, resident #010 was walking up and down the hallway and resident #012 was in an area of the home when the incident occurred. A volunteer was playing an instrument in an area of the home and facing the wall at the opposite corner. RPN #111 stated the volunteer would not be able to see resident #012.

Interview with the Director of Recreation revealed that volunteers often run programs without any program staff in attendance. He/she also revealed an awareness that resident #010 posed a risk to other residents and should be constantly monitored during programs. According to the Director of Resident Programs resident #010 was not brought to the program by the volunteer but instead just wandered in.

Review of the specific intervention provided for resident #010 revealed that this intervention ended in April 2017, and was restarted after the above incident in May 2017. Interview with BSRTL revealed a formal re-assessment to indicate resident #010 was no longer in need of the intervention was not conducted prior to it being discontinued. Interview with the DOC revealed that an assessment to assess risk was not completed even though there had been a multi-disciplinary meeting at the end of March 2017, when the discontinuation of the specific intervention was discussed. According to the DOC and record review of resident #010's progress notes revealed there was no documentation that this meeting took place and the DOC stated a risk assessment was not completed. The BSRTL stated that staff had indicated resident #010 was no longer exhibiting a responsive behaviour and that in agreement with Ontario Shores, the plan had been to wean resident #010 off the intervention. Review of the specific intervention schedule did not reveal a gradual decrease in this intervention prior to April 2017.

Interview with RN #121 from the Geriatric and Neuropsychiatry Outreach Services (GNOS) from Ontario Shores revealed it is up to the home to assess and slowly decrease the specific intervention. According to this RN, resident #010 had not had any identified behaviours from February to May 2017, at which time he/she was observed touching resident #011. This incident was reported to the MOHLTC in a CIR. Progress notes and interviews with the BSRTL revealed resident #011 was the initiator in this instance and, for this reason, the specific intervention for resident #010 was not re-implemented at that time. The BSRTL stated that if the specific intervention had been re-implemented, the incident in May 2017, most likely would not have occurred.

Interview with the DOC revealed that the home concluded that the incident that occurred between resident #010 and #011 in May 2017, was initiated by resident #011 as resident #011 was upset and lonely due to a medical condition which prohibited him/her from leaving him/her room. Frequent checks were put in place for resident #011 after the medical condition had cleared, he/she was to be immediately encouraged to become involved in his/her usual social programs. According to the DOC, no intervention was implemented to address resident #010's responsive behaviour that occurred in May 2017.

The DOC stated that the home also conducted an investigation regarding the incident in May 2017, and it was determined that PSW #106 should have intervened sooner to prevent the incident.

The Administrator confirmed that the home did not protect resident #012 from abuse as

the home is ultimately responsible for the actions of their staff.

Due to the fact that the home discontinued resident #010's specific intervention without assessing risk, failed to consider the incident in May 2017, to be an example of a continued responsive behaviour, failed to implement effective measures to protect residents, and relied on a volunteer to monitor residents during an activity involving resident #010 who has a history of an identified responsive behaviour, a referral to the Director will be made. [s. 19. (1)]

2. The licensee has failed to ensure that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Review of CIR submitted to the MOHLTC in July 2017, revealed resident #042 and #044 had verbal altercations which resulted in resident #042 hitting resident #044's body area with an identified object in June 2017. Resident #044 sustained an injury.

Interview with PSW #133 and #154 and RPN #120 and #118 revealed resident #044 has an identified responsive behaviour related to an area in the home. These staff members also stated that resident #044 is usually friendly with resident #042. Interview with RPN #120 revealed he/she was in another area when he/she noticed resident #042 and #044 talking in an area closed to both residents' rooms. RPN #120 then observed resident #042 hitting resident #044 with an identified object. RPN #120 separated the residents, dressed #044's injury and because resident #044 complained of pain gave him/her medication.

Review of resident #044's plan of care revealed the resident has an identified responsive behaviour related to an area in the home as he/she believes this to be a part of his/her apartment and staff are to reinforce it is not and encourage co-residents to other areas if resident #044 is agitated. Review of resident #044's progress notes in June 2017, revealed the resident had not been agitated prior to the above mentioned incident and that the resident had sustained an injury.

Review of resident #042's plan of care revealed the resident has responsive behaviours related to cognitive impairment and distraction techniques are useful.

Interview with the BSRTL revealed resident #044 has an identified responsive behaviour related to an area within the home and believes the above incident was a result of this responsive behaviour. The home has since referred resident #044 to Leap of Faith

Together (LOFT) at Mackenzie Health for Behaviour Support Services Mobile Support Team related to this responsive behaviour as current strategies and interventions have proven unsuccessful.

Interview with the BSRTL and ADOC confirmed the home did not protect resident #044 from resident to resident abuse. [s. 19. (1)]

3. Record review of Critical Incident Report (CIR) submitted to the Ministry of Health and Long-Term Care (MOHLTC) in March 2017, indicated resident #013 was observed to have an significant injury. Further review of the CIR indicated that resident #013 reported that he/she heard people on the roof last night and used the call bell to call for help. The resident reported that he/she did not want to let go of the call bell and was wrestling with two staff for it.

Interview with PSW #155 revealed that he/she had worked with the resident on an identified shift in March 2017, and reported that the resident did not have any identified injury and he/she had provided the resident with a shower on this day.

Interview with PSW #106 revealed that he/she had worked with the resident on an identified shift in March 2017, and that the resident did not have any injury as he/she had washed the resident's face and hands. PSW reported that resident #013's roommate, resident #041 told him/her that resident #013 had kept ringing the call on this shift in March 2017. According to resident #041 the staff came in and tried to take the call bell from resident #013 who would not give it up and the staff then ripped it from resident #013's hands.

Interview with PSW #145 who had worked with resident #013 on this shift in March 2017, revealed that the resident kept ringing the call bell and held onto it with both hands. He/she tried to open the resident's fingers to remove the call bell but the resident did not let go. Then PSW #144 came into the resident's room and he/she tried to remove the call bell but the resident was holding onto the call bell cord tightly so PSW #144 gave the call bell a light tug and got the call bell away from the resident.

Interview with PSW #144 who had worked with the resident on this shift in March 2017, revealed that the resident was holding onto the call bell tightly with both hands on the call bell cord and he/she tried to remove the call bell by tugging gently on the call bell cord.

Interview with PSW #147 revealed that when he/she went to provide care to the resident

in March 2017, the resident reported that he/she was not feeling well. The PSW removed the blankets and noticed the resident’s identified body part was injured. The PSW reported that resident #013 told him/her that staff last night tried to pull the call bell from him/her. The PSW asked the resident what the staff looked like and he/she described one staff who was wearing identified clothing with identified hair color. The PSW further revealed that resident #013’s roommate resident #041 told him/her that resident #013 kept ringing the call bell and the staff tried to take the call bell from him/her.

Interview with RPN #146 revealed that resident #013 told him/her that the staff who hurt his/her wore an identified clothing. The RPN further revealed that the resident’s roommate, resident #041, reported that the staff were trying to take the call bell from resident #013.

Interview with RN #115 revealed resident #013 reported that it was like a "tug-of-war" and the staff wrestled the call bell away from him/her. The resident told the RN that he/she was calling and two people came in.

The home's investigation notes revealed the home found PSWs #144 and #145 had not applied gentle persuasive approach (GPA) when trying to remove the call bell from resident #013 and both PSWs were given disciplinary action.

In addition, the severity is potential harm and the scope is isolated. The previous history is significant as follows:
• Inspection #2016_321501_0019: An immediate order was served on September 25, 2016, related to resident #010’s abuse of seven residents. A compliance order was also issued on November 16, 2016.
• Inspection report # 2017_626501_0004: Another compliance order was issued March 9, 2017 related to resident #010’s continued abuse.

Interview with the Administrator and ADOC revealed that the home did not protect resident #013 from physical abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

A complaint was submitted to the MOHLTC in June 2017, alleging the home has been scheduling agency staff to work instead of calling in the regular PSW staff as needed. The complainant reported to the inspector in July 2017, there is a PSW staff shortage on home areas and staff are not being replaced when ill and no baths/showers are being

provided to the residents.

PSW #125 approached inspectors #501 and #649 in July 2017, and stated the home is short staffed and baths/showers are not being provided to the residents. According to PSW #125 PSWs are being called in to start their day shift earlier than their scheduled start time.

Interview with resident #021 in July 2017, revealed that he/she was scheduled to have a tub bath that day and had not received one for several weeks which makes him/her feel dirty. The resident told the inspector that the reason he/she has not been receiving a tub bath is because the home is short of PSW staff. Review of resident #021's documentation of baths for an identified period in July 2017, indicated no evidence that the resident received baths on two identified days in July. According to the progress notes no baths were done on these two identified days because the home was short staffed.

Interview with resident #029 in July 2017, revealed that he/she is scheduled to have a shower on Mondays and Thursdays and told the inspector that he/she did not have his/her shower today and has not had his/her hair washed since the previous Monday. The resident revealed that he/she feels annoyed and self-conscious and thinks the other residents can smell him/her. The resident told the inspector that he/she reported this concern to staff in the office and was told that it has nothing to do with them in the office and to speak with the staff on the floor. The resident reported that he/she had already spoken with staff on the floor and still is not able to get his/her scheduled shower. Review of resident #029's documentation of showers for an identified period in July 2017, indicated no evidence that the resident received a shower on an identified day in July. According to a progress note no shower was done on this day because the home was short staffed.

Interview with resident #030 in July 2017, revealed that he/she is scheduled to have his/her shower on Mondays and Thursdays and told the inspector that he/she did not have his/her shower today because the home was short staffed and the staff did not have the time. The resident stated that the home is always short and a few days ago there were only two PSWs on the floor instead of the scheduled four PSWs. The resident stated that he/she had a good wash but it is not the same as a shower and he/she did not get his/her hair washed. The resident told the inspector he/she feels angry and upset when he/she does not get a shower which helps to wake him/her up and makes him/her feel fresh. According to the resident summers are the worst because of staff vacation and

the home cannot seem to fill the shifts and does not think there has been a summer since he/she had been there where the home had been fully staffed. The resident has been living at the home for almost four years. Review of resident #030's documentation of showers for an identified period in July 2017, indicated the resident did not receive a shower on an identified day in July. According to a progress note no shower was done on this day because the home was short staffed.

Interviews with RPN #108 and #112 in July 2017, revealed that the home is short PSW staff every shift. According to RPN #108 the staff on modified duties are not being replaced and have to come to work and the residents do not get their baths/showers. RPN #112 revealed when there are only two staff working on the floor and have to perform a lift that requires two staff they are unable to respond promptly to other residents' call bells.

A review of the PSW staffing hours for the period of April through mid-August 2017, revealed a significant amount of PSW hours were short in the home.

Interview with PSW #132 in July 2017, revealed staff are stressed and frustrated from constantly working short staffed. There are frequent staff call-ins and there is a high turnover of staff within the home. According to the PSW the staffing shortage is getting progressively worse. PSW #132 is concerned that residents are being neglected as they have to wait for care such as toileting when the home is short staffed.

Interview with the DOC revealed there is a PSW shortage within the home and residents probably on certain days, have not received the care they need. The DOC stated he/she is trying to hire more PSW staff but it is a challenge. The DOC further revealed that he/she had evaluated the 2017 staffing plan and made a decision to approach another staffing agency.

Interview with the Administrator and ADOC revealed that the home is not meeting the residents' assessed care needs given the high number of PSW staff shortage and reported that this has been happening since January 2017.

Due to the increase in staffing shortage during an identified period resulted in residents not receiving his/her baths/showers twice weekly, a referral to the Director is being made.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as widespread. Review of the home's compliance history revealed that a

written notification (WN) and voluntary plan of correction (VPC) were issued on March 9, 2017, under inspection report #2017_626501_0004 for non-compliance with LTCHA, 2007 O. Reg. 79/10, r. 31. (3). Due to the severity of potential for actual harm and previous non-compliance with a VPC a director referral (DR) is warranted. [s. 31. (3)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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 fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

The home submitted a CIR to the MOHLTC in July 2017, regarding an incident of staff to resident physical abuse. Review of the CIR revealed resident #033 reported to PSW #150 that PSW #152 provided care to resident #033 in a very rough manner on an identified shift in July 2017.

PSW #150 approached inspectors #649 and #501 in July 2017, regarding the above incident stating on an identified date in July 2017, he/she had reported the incident to RN

#113 and had made a written statement. PSW #150 stated he/she was concerned that management had not gotten back to him/her as they usually investigate such matters which would entail interviewing him/her. PSW #150 told inspectors that resident #033 told him/her that PSW #152 was rough with him/her during care because he/she rolled him/her over and grabbed him/her in a rough manner causing discomfort. The resident also told PSW #150 that he/she felt nervous for the next time PSW #152 would be providing care.

An interview with resident #033 revealed that PSW #152 did not know what he/she was doing and had been rough with the resident when rolling him/her in bed. The resident stated PSW #152 was pushing him/her too hard. According to resident #033 he/she is unable to roll over on his/her own because he/she has a medical condition.

Review of the home's investigation notes revealed the Administrator and DOC interviewed resident #033 in July 2017. During this interview resident #033 downplayed the incident and stated PSW #152 needs to improve his/her technique when rolling residents over. The resident did state PSW #152 was "pretty rough with me" and he/she must be inexperienced. Resident #033 also stated he/she had no problem with PSW #152 providing his/her care in the future.

Interview with RN #113 revealed resident #033 does not like to complain. According to RN #153, if resident #033 has a complaint it would be legitimate. Further interview with PSW #150 revealed he/she was positive that resident #033 was uneasy about having PSW #152 care for him/her and stated the resident might have downplayed the incident to the DOC and the inspector because he/she was embarrassed about creating a commotion.

Interview with PSW #152 revealed he/she was aware he/she was doing something wrong because he/she remembers resident #033 saying "ouch". PSW #152 also admitted to the inspector that he/she could improve respecting the Residents' Right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Interviews with the ADOC and Administrator confirmed the home failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully

respected and promoted. Every resident has the right to 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 have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

During the observation of a medication pass on July 14, 2017, on a home area the inspector observed RPN #114 discarding the residents’ medication pouches into a garbage bin at the side of the medication cart.

Review of resident #020’s medication pouches consisted of the resident name, room number and bed number as well as the names and times of his/her medications.

Interview with the RPN #114 revealed that the residents’ medication pouches are discarded in the garbage bin on the side of the medication cart.

Interview with RN #115 revealed that the residents’ medication pouches are discarded into the garbage and did not think it was the right method to dispose of the residents’ medication pouches.

Interview with the DOC revealed that it is the home’s expectation for the medication pouches to be stored in a drawer on the medication cart and at the end of the shift discarded into the shredder box to protect residents’ personal health information. [s. 3. (1) 11. iv.]

3. The following observations were made of the e-MAR screen being left unlocked displaying residents' personal health information:
-On August 14, 2017, at 1224 and 1524 hours respectively the inspector observed the e-MAR screen on the medication cart on a home area unlocked with a resident's personal health information being displayed. Interview with RPN #139 and #140 respectively revealed the e-MAR screen should not have been left unlocked when not in use.

-On August 10, 2017, at 1545 hours the inspector observed the e-MAR screen on a home area unlocked with a resident's personal health information being displayed. The medication cart was observed in an area of the home, one resident was observed beside the medication cart in his/her wheelchair and another residents was noted to be sitting in the home area in his/her wheelchair a few feet away from the medication cart. Interview with RPN #137 revealed that the e-MAR screen should not have been left unlocked when not in use.

-On August 10, 2017, at 1550 hours the inspector observed the e-MAR screen on medication cart on a home area unlocked with a resident's personal health information being displayed. Several residents were observed walking passed the medication cart outside residents' rooms and the RPN #112 was observed further down the hall assisting a resident in a wheelchair with a snack. Interview RPN #112 revealed that the e-MAR screen should not have been left unlocked when not in use.

-On July 28, 2017, at 0835 hours the inspector observed the e-MAR screen on the mediation cart on a home area unlocked with a resident's personal health information being displayed. The medication cart was observed in an area of the home where several residents were observed sitting a few feet away from the medication cart. Interview with RPN #143 revealed that the the e-MAR screen should not have been left unlocked when not in use.

-On July 26, 2017, at 1205 and 1310 hours respectively the inspector observed the e-MAR screen on the medication cart on a home area unlocked with a residents’ personal health information being displayed. The medication cart was observed in an area of the home at 1205 hours in front of residents' rooms. The RPN #114 left the e-MAR screen unlocked and went into another area of the home then returned to the medication cart. Later that day on the same unit at approximately 1310 hours the e-MAR screen was observed unlocked on the medication cart which was observed in an area of the home outside of residents rooms. The RPN #114 was observed in another area of the home. Interview with RPN #114 revealed that the e-MAR screen should not have been left unlocked when not in use.

Interview with the ADOC and DOC revealed the e-MAR screen should be kept locked when not in use to protect residents’ personal health information. [s. 3. (1) 11. iv.]

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 has fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity and that the following rights of residents are fully respected and promote. Every resident has the right to 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 have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #8: 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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On July 14, 2017, at approximately 1025 hours while conducting a narcotic count with RPN #114 on a home area the following were noted:
- Residents #019, #022, #023, and #024's narcotic medications did not match the number of tablets on the card

A review of the home's policy titled Administering and Documenting Controlled Substances, revision date of November 2015, revealed "the controlled substance medication is initialed as administered, on the MAR, in the correct box, immediately after administration and before the next resident is medicated".

Interview with RPN #114 revealed that he/she had administered the medications to the residents but had not signed the narcotic sheet at the time of administration.

Interview with RN #115 revealed when the medication is given, sign the narcotic and controlled count sheet at the time of administration.

Interview with the DOC revealed each resident had an individual narcotic and controlled count sheet and as soon as the medication is given it should be signed and not at the end of the shift. [s. 8. (1) (b)]

2. During the observation of a medication pass on July 14, 2017 on a home area, resident #020 was ordered an Ophthalmic medication, one drop three times a day. The opened date on the Ophthalmic medication was June 12, 2017.

A review of the home's policy titled Medication Risk Management dated November 2015, revealed Ophthalmic/Otic products are not recommended for use beyond 28 days once opened to maintain sterility, unless otherwise specified.

Interview with RPN #114 and RN #115 revealed that the Ophthalmic medication is valid for 30 days days once opened.

Interview with DOC revealed that the Ophthalmic medication is valid for 28 days once opened. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident of the home is bathed, at a minimum, twice a week by a method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the MOHLTC in June 2017, alleging the home has been scheduling agency staff to work instead of calling in the regular PSW staff as needed. The complainant reported to the inspector in July 2017, there is a PSW staff shortage on home areas and staff are not being replaced when ill and no baths/showers are being provided to the residents.

-Review of resident #021's documentation of baths for an identified period in July 2017, indicated no evidence that the resident received baths on two identified days in July. According to the progress notes no baths were done on these two identified days because the home was short staffed.

-Review of resident #029's documentation of showers for an identified period in July 2017, indicated no evidence that the resident received a shower on an identified day in

July. According to a progress note no shower was done on this day because the home was short staffed.

-Review of resident #030's documentation of showers for an identified period in July 2017, indicated the resident did not receive a shower on an identified day in July. According to a progress note no shower was done on this day because the home was short staffed.

A review of the documentation of showers and progress notes for the above mentioned residents during the above mentioned times did not indicate a substituted bath/shower had been provided to the residents following missed baths/showers.

Interview with RPN #114 and RN #115 revealed the residents did not receive their scheduled showers/baths on the above mentioned days. RN #115 stated that the home is short of PSW staff mostly on the weekends and will try to book a staff for baths/showers on the Monday but if unable to locate staff to work on the Monday then the baths/showers are not provided. The RN further revealed that by the time a staff is secured for the baths/showers the resident's next shower is due.

Interview with the Administrator and ADOC revealed that the above mentioned residents should have received their baths/showers regardless of the staff shortage. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by a method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered staff, if clinically indicated.

Resident #001 triggered from stage one of the RQI for altered skin integrity. Record review of the home's skin and wound assessments indicated in May 2017, resident #001 had a altered skin integrity on an identified body area. According to a progress notes dated June 2017, the altered skin integrity had healed on the resident's identified body area.

A review of the home's skin and wound assessments indicated that no skin and wound assessments had been completed in May and June 2017, for resident #001.

Interviews with RPN #108 and RN #113 revealed that a skin and wound assessment should have been completed in May and June 2017, for resident #001.

Interview with DOC revealed that a resident exhibiting skin breakdown or altered skin integrity should have been reassessed by a member of the registered staff in May and June 2017. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered staff, if clinically indicated, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The home has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include reassessment.

CIR was submitted to the MOHLTC in May 2017, related to resident to resident abuse. The CIR revealed PSW #106 reported, he/she witnessed resident #010 standing on the left side of resident #012 in an area of the home where both residents were participating in a program. Resident #012 was sitting in his/her wheel-chair at the time and facing away from PSW #106. According to the CIR, the PSW observed resident #012 touch resident #010. PSW #106 separated the residents. PSW #106 then called resident #010 out into the hallway who then returned to his/her room. Resident #012 did not sustain any injuries and no ill effects were identified.

During an interview PSW #106 stated resident #010 did not receive an identified intervention on the above mentioned day and interviews with RPN #111 and RN #113 revealed they were not aware why resident #010 no longer had the identified intervention at that time.

Review of the identified intervention provided for resident #010 revealed that the intervention ended on an identified date and was restarted after the above mentioned incident. An interview with the BSRTL revealed a re-assessment to indicate resident #010 was no longer in need of the intervention was not conducted prior to it being discontinued and this is something that he/she would consider doing in the future.

Interview with the DOC confirmed the home did not do a reassessment of resident #010's responsive behaviours to indicate that the identified intervention was no longer necessary. [s. 53. (4) (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 the actions taken to meet the needs of the resident with responsive behaviours include reassessment, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of CIR submitted to MOHLTC in June 2016, indicated that resident #015 was found with blood running down his/her body part and resident #014 was noted to be sitting on resident #015's bed at the time of the incident.

Record review of resident #014's progress notes indicated that resident #014's had exhibited numerous incidents of inappropriate behaviours towards other residents in May and June 2016.

Interview with the ADOC revealed that resident #014 was started on a specific intervention after the incident in May 2016, with resident #035 and staff were to monitor and intervene if resident #014 had any responsive behaviours. The ADOC further revealed that a referral had been sent to LOFT and Ontario Shores and LOFT came into the home to start assessing the resident in June 2016. According to the ADOC the specific intervention was not frequently available on the above mentioned days when the incidents of responsive behaviour had occurred several times in June 2016.

Interview with the DOC revealed that when the behaviours started a specific intervention was implemented in June 2016. The specific intervention was not frequently available when additional incidents of responsive behaviours had occurred in June 2016. According to the DOC the specific intervention was to prevent and distract resident #014 and prevent any escalating behaviours with other residents and minimize risk of harm. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care program includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

Record review during stage one of the RQI revealed seven residents did not have recent heights recorded in their electronic documentation system as follows:
• Resident #005's last height was recorded as having been taken in 2014
• Resident #008, #016, #031, #032, #033, and #034's last height was recorded as having been taken in 2015
In addition, resident #006 was admitted to the home in May 2017, and only after it was brought to the DOC's attention did the home measure the resident's height in July 2017.

Review of the home's policy #16 titled Height Management dated February 23, 2017, revealed that all residents' heights are taken on admission and annually thereafter.

Interview with the DOC confirmed the home has not been taking heights on admission and annually thereafter. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the nutrition care program includes a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring staff member.

Review of staff member #142's personnel file revealed his/her first day of employment was in May 2015, and a criminal reference check was not completed until July 2017. date.

Interview with the ADOC confirmed the home did not ensure that a criminal reference check for staff member #142 was conducted prior to hiring the staff member. [s. 75. (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 criminal reference checks are conducted prior to hiring staff member, to be implemented voluntarily.

WN #15: 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 ensure that steps are taken to ensure the security of the drug supply including all areas where drugs were stored shall be kept locked at all times, when not in use.

On July 14, 2017, at approximately 1405 hours the inspector observed a topical prescription medication in resident #001's room.

Interviews with RPN #108, ADOC and DOC revealed the identified topical medication should be locked in the treatment cart when not in use. [s. 130. 1.]

2. On July 18, 2017, at approximately 0815 hours, the inspector observed the medication cart unlocked in an home area including the e-MAR screen and the narcotic box.

In the top drawer of the medication cart the inspector observed a medication pouch and supplies such as straws and gloves. In the second, third and fourth drawers observed residents' medication in pouches. In the bottom drawer the narcotic drawer was observed unlocked.

Interview with RPN #120 revealed that the medication cart should be kept locked when he/she stepped away from the cart.

Interviews with the DOC and RN #115 revealed the medication cart should be locked when not in use and the narcotic drawer double locked. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

During the observation of a medication pass on July 14, 2017, on a home area, resident #020 did not receive his/her prescribed medication as specified by the prescriber.

Review of resident #020's physician order dated July 2017, read as follows:
An identified medication and dose by mouth three times a day for three days then, twice daily for three days then, once daily for three days then discontinue.

A review of resident #020's MAR for the month of July 2017, read as follows:
-An identified medication and dose was administered to the resident three times a day, on identified days in July 2017
-An identified medication and dose was administered to the resident twice daily, on identified days in July 2017
-An identified medication and dose was administered to the resident once daily, on an identified day in July 2017, the resident had not received the identified medication on two identified days in July 2017

Interview with RPN #114 revealed that he/she had worked on the first date in July 2017, and confirmed resident #020 had not received the identified medication at 0700 hours as the medication was unavailable. Resident #020 did not receive the identified medication at 0700 hours on the second date in July 2017, during observation of the medication pass. The RPN further told the inspector that it is the home's practice to call the pharmacy to advise of a medication shortage and endorse to the evening shift to follow up. The RPN had not notified the pharmacy of the shortage of the medication on the first date in July 2017, when it was not available.

Review of the home's Drug Record Book (DRB) revealed that the identified medication had not been reordered on the first date in July 2017, when it was not available.

Interview with RN #115 revealed the RPN should have called the pharmacy or notified him/her if he/she was too busy of the medication shortage. The RN stated that he/she had worked on first date in July 2017, and was not informed of the identified medication shortage for resident #020.

Interview with the DOC revealed if the medication is not available in the emergency (STAT) box the RPN should have called the satellite pharmacy who is close by to have the medication delivered. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of the home's Medication Incident Reports for April, May and June 2017, were reviewed as part of the RQI. The Medications Incident Reports revealed that resident #034 and #040 substitute decision makers (SDMs) had not been notified of the medication incidents.

A review of resident #034 and #040 completed Medication Incident Reports indicated that the residents SDM had not been notified of the medication incidents when they had occurred. Further review of resident #034 and #040's progress notes did not indicate any documentation that the SDM had been notified of the medication incidents at the time the incidents had occurred.

Interview with the DOC and ADOC revealed that the SDMs of residents' #034 and #040 should have been immediately informed of the medication incidents. [s. 135. (1)]

2. The licensee has failed to ensure that a written record is kept of everything provided for in clauses (a) and (b).

Review of the home's Medication Incident Reports for months April, May and June 2017, revealed five medications incidents.

Interview with the DOC and ADOC revealed that the medication incidents for the last three months had not been reviewed and a written record kept. The DOC revealed the home plans to have medication incidents discussed at the Professional Advisory Committee (PAC) meeting and stated the medication incidents are now being faxed to the pharmacy to be compiled. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, that a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident was assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Resident #008 triggered from stage one of RQI for restraints. A review of resident #008's written plan of care indicated to ensure an identified number of bed rails are up.

Observations on July 17, 2017, at approximately 1525 hours resident #008 was observed in bed with an identified number of bed rails in the up position.

A review of resident's #008 clinical records did not indicate that the resident had been assessed and bed system evaluated when the identified number of of bed rails were initiated in May 2015.

Interview with RPN #103 and the ADOC revealed that he/she did not think the home had an assessment tool to assess the resident and evaluate the bed systems of those residents who use bed rails. The DOC and ADOC revealed that no bed system assessment had been completed for resident #008. [s. 15. (1) (a)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: alternative to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Resident #008 triggered from stage one of RQI for restraints. Observations on July 18 and July 21, 2017, at 1455 hours and 1300 hours, respectively revealed resident #008 was using his/her safety device when up in the wheelchair.

A review of resident #008's written plan of care indicated to apply the safety device for

meals and activities and comfort as per the SDM request.

A review of the home's policy titled PASD #RCSM G-90 revised May 2016, revealed that mandatory documentation is required in the progress notes:
-Identified concern, activity of daily living that would benefit from the use of a PASD
-Alternatives that have been trialed
-Discussion with resident/substitute decision maker regarding rationale for use of PASD and consent obtained

Interview with the DOC and ADOC revealed no alternatives were documented as having been tried prior to the use of resident #008's safety device. [s. 33. (4) 1.]

2. The licensee has failed to ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: the use of the PASD has been approved by,
(i) a physician,
(ii) a registered nurse,
(iii) a registered practical nurse,
(iv) a member of the College of Occupational Therapist of Ontario,
(v) a member of the College of Physiotherapists or Ontario, or
(vi) any other person provided for in the regulation

Resident #008 triggered from stage one of RQI for restraints.

A review of resident #008's written plan of care indicated to apply the safety device for meals, activities and comfort as per the SDM request.

Observations on July 18 and July 21, 2017, at 1455 hours and 1300 hours, respectively revealed resident #008 was using his/her safety device when up in the wheelchair.

Interviews with the DOC and ADOC revealed that the safety device had not been approved by any of the above mentioned professionals for use by the resident. [s. 33. (4) 3.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

CIR was submitted to the MOHLTC in May 2017, related to resident to resident abuse. According to the CIR, PSW #106 observed resident #011 and #010 inappropriately touching in a public area of the home. Resident #011 was noted to be restless that day due to a medical condition which prohibited him/her from leaving him/her room. Both residents were distracted by staff and resident #010 was easily redirected.

Review of the CIR which was amended on an identified date indicated that immediate actions taken to prevent recurrence and long term actions planned to correct the situation and prevent recurrence were "pending".

Interview with the DOC who initiated the report confirmed that the home failed to include the above mentioned items related to analysis and follow up in the CIR. [s. 104. (1) 4.]

WN #21: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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 ensure that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the name of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Review of the home's annual evaluation of the infection prevention and control (IPAC) policy for 2016, evaluated on March 4, 2017, by the home's IPAC lead and the Public Health Representation did not include the date the changes were to be implemented.

Interview with the ADOC revealed that the date the changes were to be implemented was not included on the written evaluation of the IPAC program. [s. 229. (2) (e)]

2. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On July 14, 2017, during an observation of the medication pass on an home area RPN #114 did not practice hand hygiene in between different routes of administration while administering medications to resident #020.

The inspector observed RPN #114 administered eye drops, a puffer and oral medications without practicing any hand hygiene in between these activities.

Interview with the RPN #114 revealed it is probably a good idea to practice hand hygiene in between the different routes and could have washed his/her hands in the washroom.

Interview with the RN #115 revealed that he/she did not think the RPN really needed to wash his/her hands in between the different routes of administration.

Interview with the DOC revealed hand hygiene should have been done between the different routes of administration. [s. 229. (4)]

Issued on this 10th day of November, 2017

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) :	JULIEANN HING (649), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2017_370649_0014
Log No. / No de registre :	013266-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 25, 2017
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	RIVER GLEN HAVEN NURSING HOME 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Ryan

To ATK CARE INC., 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2016_353589_0019, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care was provided to residents #002, #010, #017, #045, and #046 as specified in the plan.

The plan will include, at a minimum, the following elements:
1. A documented monitoring process to ensure all appropriate staff received training to ensure residents #017, #045 and #046 and other residents whose plan of care requires the assistance of two staff members for ambulation exercises receive the appropriate assistance as specified in the plan of care
2. A documented monitoring process to ensure all appropriate staff received training to ensure resident #002 and other residents whose plan of care requires specific dietary restrictions receive the appropriate diet as specified in the plan
3. A documented monitoring process to ensure all appropriate staff received training to ensure resident #010 and other residents whose plan of care requires interventions to manage responsive behaviours receive such interventions as specified in the plan of care

Please submit the plan to Julieann.hing@ontario.ca no later than October 30, 2017.

Grounds / Motifs :

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

A complaint was submitted in June 2017, to MOHLTC alleging that resident

#017 who had returned from hospital on a Thursday with an injury had to wait in bed until the following Monday to be assessed by the Physiotherapist (PT). A second complaint was reported by the Physiotherapist Assistant (PTA) to the MOHLTC inspector in July 2017, alleging that residents who require two staff for therapy may be neglected as there is only one PTA in the home.

Review of resident #017's written plan of care indicated that he/she was to participate in gait training and ambulation exercises at identified weekly intervals with two staff.

Review of resident #045's recent plan of care indicated for the resident to receive gait training and ambulation exercises using a walker at identified weekly intervals with two staff.

Review of resident #046's recent plan of care indicated the resident was to participate in the mobility exercises at identified weekly intervals with two staff.

Interview with the PTA #141 revealed that he/she alone had assisted resident #017, #045 and #046 with ambulation exercises in July and August 2017, and had not followed the residents' plan of care to receive ambulation exercises with two staff.

Interview with the ADOC and DOC revealed that the plan of care for residents' #017, #045 and #046 had not been followed and the PTA should have asked another staff member to assist with the ambulation of the residents.
(649)

2. CIR was submitted to the MOHLTC in May 2017, related to inappropriate touching. According to the CIR, PSW #106 observed resident #011 and #010 inappropriately touching in a public area of the home. Resident #011 was noted to be restless that day due to a medical condition which prohibited him/her from leaving him/her room. Both residents were distracted by staff and resident #010 was easily redirected.

Interview with PSW #106 revealed he/she observed resident #010 in an area of the home near to resident #011's room. Resident #010 was observed to touch resident #011. When PSW #106 attempted to distract resident #010 he/she touched resident #011 before walking away. According to the PSW, resident #010 is most active at identified times when staff are busy tending to other

residents in their rooms.

Review of resident #010's plan of care revealed there is a focus for responsive behaviours related to inappropriately touching other residents. The intervention is to check the resident at intervals during certain times and keep the resident occupied with an activity.

Interview with BSRTL revealed resident #010 exhibited a decline in his/her ability to ambulate along with an alteration in the resident's level of cognitive functioning following adjustments to the resident's medication regime to manage the responsive behaviours. Resident #010 became wheelchair bound for a short time. According to progress notes, resident #010 recovered from these setbacks and was independently mobile again in April 2017.

Progress notes revealed there was a multidisciplinary meeting in May 2017, to discuss the incident of resident #010 and #011's inappropriate touching. Documentation revealed the purpose of the meeting was to remind staff of distractions that are in place for resident #010 which included assisting with an activity.

Interview with the BSRTL confirmed that the home had lost sight of interventions to address resident #010's responsive behaviours and were not consistently implementing the activity after the resident recovered in April 2017. An interview with the DOC confirmed the home failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan. (501)

3. Resident #002 triggered from stage one of the RQI for eating decline since admission. Record review revealed resident #002 was admitted to the home in December 2016, and according to the MDS assessment the resident leaves a certain percentage of food uneaten at most meals.

Review of resident #002's most recent plan of care revealed the resident had been assessed to require a special diet including fluid restrictions. According to his/her dietary restrictions posted in the home, which included whole wheat breads be limited and only an identified amount of fluids offered at lunch.

Observation on July 21, 2017, during a meal revealed resident #002 was provided with identified amounts of fluids a well as a whole wheat bun as part of his/her entrée. The resident partially consumed the whole wheat bun and did not

consume all the fluids.

Interview with the Dietary Aide (DA) #126 revealed he/she did not have any white bread rolls and he/she needed to review the dietary restrictions. Interview with PSW #116 who served the fluids revealed he/she was unsure about resident #002's fluid restriction. According to RPN #131, resident #002 is served several fluids because he/she has poor fluid consumption and they watch and monitor to see what he/she will consume.

Observation on July 22, 2017, during lunch revealed resident #002 was not offered soup. Interview with PSW #130 revealed he/she did not offer resident #002 soup because he/she thought resident #002 was on a fluid restriction.

Interview with the Director of Support Services (DSS) and the Registered Dietitian (RD) revealed resident #002 should not have been served a whole wheat bun and should have only been served the identified amount of fluids on July 21, 2017. Interview with the RD revealed resident #002 should be offered the identified fluid type as long as his/her total fluid consumption did not exceed an identified amount.

Interview with the DSS and the RD confirmed that the care set out in the plan of care was not provided to resident #002 as specified in the plan on the above mentioned days.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a compliance order (CO) was issued on February 6, 2017, under inspection report #2016_353589_0019 for non-compliance with LTCHA, 2007 S.O. 2007 c.8, s. 6. (7). Due to the severity of potential for actual harm and previous non-compliance with a CO a compliance order is warranted. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that every alleged, suspected or witnessed abuse of a resident by anyone that the license knows of, or that is reported is immediately investigated.

The plan will include, at minimum, the following elements:
1. Education to be provided to management related to what constitutes alleged, suspected or witnessed abuse of a resident and needs to be immediately investigated
2. Education to be provided to all non-management staff regarding what measures are available for them to take should they suspect reported abuse has not been investigated
3. What steps the home will take for such investigations and when these steps will be initiated and by whom
4. Specify who the home will interview and when
5. Development of appropriate scripts to use when interviewing witnesses and residents
6. Creation of detailed legible documents for each investigation that includes action the home has taken to prevent recurrence of abuse

Please submit the plan to susan.semeredy@ontario.ca no later than October 30, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed abuse of a resident by anyone that the license knows of, or that is reported is immediately investigated.

The home submitted CIR to the MOHLTC in July 2017, regarding an incident of staff to resident abuse. Review of the CIR revealed resident #033 reported to PSW #150 that PSW #152 provided care to resident #033 in a very rough manner on an identified shift in July 2017.

PSW #150 approached inspectors #649 and #501 in July 2017, regarding the above incident stating on an identified date in July 2017, he/she had reported the incident to RN #113 and provided a written statement. PSW #150 stated he/she was concerned that management had not gotten back to him/her as they usually investigate such matters which would entail interviewing him/her. PSW #150 told inspectors that resident #033 told him/her that PSW #152 was rough with him/her during care because PSW #152 rolled the resident over and

grabbed him/her in a rough manner which made the resident feel concerned. The resident also told PSW #150 that he/she felt nervous for the next time PSW #152 would be providing care.

An interview with the Administrator and DOC in July 2017, revealed the DOC was aware of this incident but had not immediately investigated it because he/she viewed it as a complaint and not an allegation of abuse.

Review of PSW #150's statement that was sent and received by the DOC revealed resident #033 felt as though he/she was treated in a disrespectful way and was nervous for the next time PSW #152 does his/her care.

Interview with RN #133 revealed he/she was informed of the incident by PSW #150 on an identified date in July 2017, and he/she remembered contacting the DOC the same day. The DOC told the RN to obtain a statement from PSW #150 and document his/her own statement of an interview with resident #033 and place these underneath his/her office door.

Further interviews with the DOC were not obtained since he/she was away for medical reasons. Interview with the Administrator revealed that the process in the home is to immediately investigate an allegation of rough handling of a resident because it could be a form of abuse. The Administrator could not explain why this was not immediately investigated and confirmed that the home did not immediately investigate this incident of alleged abuse.

The severity of this non-compliance was identified as actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on November 16, 2016, under inspection report #2016_321501_0019 for non-compliance with LTCHA 2007 S.O. 2007 c.8, s.23. (1) (a). Due to the severity of actual harm and previous non-compliance with a VPC a compliance order is warranted. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately reported with the information upon which it is based to the Director.

The plan will include, at minimum, the following elements:
1. Education to be provided separately to management, registered staff in charge of the building and all other staff related to what constitutes abuse or neglect and what their roles are in relation to mandatory reporting
2. All staff to be informed about what measures are available for them to take if they suspect reported abuse has not been reported to the Director
3. The plan will specify when this training will occur and by whom
4. The creation of documentation to ensure all staff have received the above training

Please submit the plan to susan.semeredy@ontario.ca no later than October 30, 2017.

Grounds / Motifs :

1. The home has failed to ensure that the person who had reasonable grounds to suspect that abuse of resident by anyone that posed a risk of harm immediately report the suspicion and the information upon which it was based to the Director.

The home submitted CIR to the MOHLTC in July 2017, regarding an incident of staff to resident abuse. Review of the CIR revealed that resident #033 reported to PSW #150 that PSW #152 provided care to resident #033 in a very rough manner on an identified shift in July 2017.

PSW #150 approached inspectors #649 and #501 in July 2017, regarding the above incident stating on an identified date in July 2017, he/she had reported this incident to RN #113 and had provided a written statement. PSW #150 stated he/she was concerned that management had not gotten back to him/her as they usually investigate such matters which would entail interviewing him/her. PSW #150 told inspectors that resident #033 told him/her that PSW #152 was rough with him/her during care because PSW #152 rolled the resident over and grabbed him/her in a rough manner that caused concern to the resident. The resident also told PSW #150 that he/she felt nervous for the next time PSW #152 would be providing care. In a further interview PSW #150 revealed that resident #033 had also told PSW #151 who worked the shift that the incident occurred.

Interview with PSW #151 revealed that a day or two after the incident resident #033 asked the PSW who was the other PSW that worked with him/her and PSW #151 told the resident it was PSW #152. Resident #033 then told PSW #151 that PSW #152 was very rough. PSW #151 stated he/she reported this to RN #153.

Interview with RN #153 revealed PSW #151 reported that resident #033 reported PSW #152 had been rough with the resident. RN #153 stated he/she left a message on the ADOC's phone and did not call the the MOHLTC. Interview with the ADOC revealed he/she did not receive this message until after he/she returned from his/her vacation at which time he/she asked the DOC if he/she was aware of the incident and the DOC responded that he/she was looking after the matter.

Interview with RN #113 revealed he/she did not report the incident to the MOHLTC after PSW #150 reported the incident because he/she had a

conversation with RN #153 who stated he/she had already informed the ADOC.

Interview with the Administrator and DOC in July 2017, revealed the DOC was aware of this incident but had not reported it to the MOHLTC because he/she viewed it as a complaint and not an allegation of abuse. According to the home's investigation notes this complaint was submitted to the MOHLTC because inspector #501 requested the DOC to do so despite the fact that the resident who is competent did not identify the actions of PSW #152 as abusive.

Interviews with PSW #150, #151, #152, RN #113, #153 and the Administrator revealed that rough handling may constitute physical abuse as it poses a risk of physical harm to residents. According to PSW #150, resident #033 was nervous to have PSW #152 care for him/her again because the resident has had a medical condition and did not want to have any further injury.

Interview with resident #033 revealed that PSW #152 had been rough with him/her when rolling him/her in bed as the PSW was pushing him/her too hard and the resident had to hold onto the bed rail. According to resident #033 he/she is unable to roll over on his/her own because he/she has a medical condition. Interview with PSW #152 revealed he/she was aware he/she was doing something wrong because he/she remembers resident #033 saying "ouch".

Interview with the Administrator confirmed the home should have contacted the MOHLTC immediately following the allegation of rough handling which posed the risk of physical harm to resident #033.

The home failed on three occasions to inform the MOHLTC of this incident and even after doing so, did not recognize the severity of the incident and the necessity to report, as evidenced by the DOC's documentation related to the resident downplaying the incident as not being abusive. Further interviews with the DOC were not obtained since he/she was away for medical reasons.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and compliance order (CO) were issued on November 16, 2016, under inspection report #2016_321501_0019 for non-compliance with LTCHA 2007 S.O. 2007 c.8, s. 24. (1). Due to the severity of potential for actual harm and previous non-compliance with a CO a compliance order is warranted. (501)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall ensure that when resident #001 and #003 have fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Upon receipt of this compliance order the licensee shall:
1. Develop a process to ensure all appropriate staff have received documented training of the condition or circumstances in which a post-fall assessment is conducted using the homes clinically appropriate assessment tool as per the home's policy.
2. The implementation of the home's post-falls audit system review tool by end of October 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #003 triggered from stage one of the RQI for fall prevention. A review of resident #003's written plan of care revealed that the resident was at risk for falls related to a history of falls, injury and multiple risk factors.

A review of resident #003's falls documented in the progress notes and risk management section revealed the resident fell 12 times during January to July

2017. Further review revealed when the resident fell in July 2017, no post fall assessment had been completed under the assessment tab in PCC on these dates.

A review of the home's policy titled Fall Prevention and Management #RCSM G-40 dated February 2017, revealed when a resident sustains a fall, a fall assessment is completed under the assessment tab in PCC.

Interviews with the RPN #103, #112, ADOC, and DOC revealed that no post fall assessment had been conducted in PCC under the assessment tab using a clinically appropriate assessment instrument that is specifically designed for falls when the resident fell twice in July 2017. (649)

2. Resident #001 triggered from stage one of the RQI for falls prevention. A review of resident #001's written plan of care revealed that the resident is at high risk for falls related to a history of falls with injury, multiple risk factors and non-compliance with mobility aid.

A review of resident #001's falls documented in the progress notes and risk management section revealed the resident fell 17 times during January to June 2017. Further review revealed when the resident fell in April, May, and June 2017, no post fall assessment had been completed under the assessment tab in PCC on these dates.

A review of the home's policy titled Fall Prevention and Management #RCSM G-40 dated February 2017, revealed when a resident sustains a fall, a fall assessment is completed under the assessment tab in PCC.

Interviews with RPN #103, #112, ADOC and DOC revealed that no post fall assessment had been conducted in PCC under the assessment tab using a clinically appropriate assessment instrument specifically designed for falls when the resident fell in April, May, and June 2017.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as isolated. Review of the home's compliance history revealed that a written notification (WN) and compliance order (CO) were issued on February 6, 2017, under inspection report #2016_353589_0019 for non-compliance with the LTCHA, 2007 O.Reg. 79/10, r.49. (2). Due to the severity of potential for actual harm and previous non-compliance with a CO a compliance

order is warranted. (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Order # / Ordre no : 005

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

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 shall prepare, submit, and implement a compliance plan outlining how they will come into compliance with s. 19 and keep residents safe from resident #010. The plan will include but not be limited to the following elements:

1. The licensee will implement the specific intervention during resident #010's waking hours to ensure someone is with him/her at all times.
2. Resident #010 will remain on the specific intervention until a formal re-assessment to indicate resident #010 is no longer in need of this intervention.
3. The Director will be notified in writing if and when the specific intervention is discontinued.
4. Documented education of staff training on accountability in caring for residents with responsive behaviours to ensure staff understand what is in place to deal with resident behaviours and what constitutes their roles.
5. Licensee will review/assesses the volunteer responsibilities and job descriptions for volunteers.

Please submit the plan to susan.semeredy@ontario.ca no later than October 30, 2017.

Grounds / Motifs :

1. The licensee has failed to protect resident #012 from abuse.

CIR was submitted to the MOHLTC in May 2017, related to resident to resident abuse. The CIR revealed PSW #106 reported, he/she witnessed resident #010 standing on the left side of resident #012 in an area of the home where both residents were participating in a program. Resident #012 was sitting in his/her wheel-chair at the time and facing away from PSW #106. According to the CIR,

the PSW observed resident #012 touch resident #010. PSW #106 then called resident #010 out into the hallway who then returned to his/her room. Resident #012 did not sustain any injuries and no ill effects were identified.

Previous inspection report #2016_321501_0019 submitted to the home in November 2016, found resident #010 had abused an identified number of residents from April to September 2016, in an identified number of documented instances, several of which involved resident #012.

Interviews with the BSRTL revealed resident #012 has not been assessed for capacity and consent related to the responsive behaviours. Review of resident #010's plan of care revealed the resident is to be provided constant supervision during programs.

Interview with PSW #106 revealed in May 2017, he/she observed resident #012 exhibiting a responsive behaviour towards resident #010. The PSW separated the residents. According to PSW #106, it is not possible to constantly monitor resident #010 and it is a volunteer that runs the program on identified days with no activity staff in attendance.

Interview with RPN #111 revealed in May 2017, PSW #106 reported that he/she observed resident #010 touch resident #012 during a program. According to RPN #111, resident #010 was walking up and down the hallway and resident #012 was in an area of the home when the incident occurred. A volunteer was playing an instrument in an area of the home and facing the wall at the opposite corner. RPN #111 stated the volunteer would not be able to see resident #012.

Interview with the Director of Resident Programs revealed that volunteers often run programs without any program staff in attendance. He/she also revealed an awareness that resident #010 posed a risk to other residents and should be constantly monitored during programs. According to the Director of Resident Programs resident #010 was not brought to the program by the volunteer but instead just wandered in.

Review the specific intervention provided for resident #010 revealed that this intervention ended in April 2017, and was restarted after the above incident in May 2017. Interview with BSRTL revealed a formal re-assessment to indicate resident #010 was no longer in need of the intervention was not conducted prior to it being discontinued. Interview with the DOC revealed that an assessment to

assess risk was not completed even though there had been a multi-disciplinary meeting at the end of March 2017, when the discontinuation of the specific intervention was discussed. According to the DOC and record review of resident #010's progress notes revealed there was no documentation that this meeting took place and the DOC stated a risk assessment was not completed. The BSRTL stated that staff had indicated resident #010 was no longer exhibiting a responsive behaviour and that in agreement with Ontario Shores, the plan had been to wean resident #010 off the intervention. Review of the specific intervention schedule did not reveal a gradual decrease of this intervention prior to April 2017.

Interview with RN #121 from the Geriatric and Neuropsychiatry Outreach Services (GNOS) from Ontario Shores revealed it is up to the home to assess and slowly decrease the specific intervention. According to this RN, resident #010 had not had any identified behaviours from February to May 2017, at which time he was observed touching resident #011. This incident was reported to the MOHLTC in a CIR. Progress notes and interviews with the BSRTL revealed resident #011 was the initiator in this instance and, for this reason, the specific intervention for resident #010 was not re-implemented at that time. The BSRTL stated that if the specific intervention had been re-implemented, the incident in May 2017, most likely would not have occurred.

Interview with the DOC revealed that the home concluded that the incident that occurred between resident #010 and #011 in May 2017, was initiated by resident #011 as resident #011 was upset and lonely due to a medical condition which prohibited him/her from leaving him/her room. Frequent checks were put in place for resident #011 after the medical condition had cleared, he/she was to be immediately encouraged to become involved in his/her usual social programs. According to the DOC, no intervention was implemented to address resident #010's responsive behaviour that occurred in May 2017.

The DOC stated that the home also conducted an investigation regarding the incident in May 2017, and it was determined that PSW #106 should have intervened sooner to prevent the incident.

The Administrator confirmed that the home did not protect resident #012 from abuse as the home is ultimately responsible for the actions of their staff.

Due to the fact that the home discontinued resident #010's specific intervention

without assessing risk, failed to consider the incident in May 2017, to be an example of continued responsive behaviour, failed to implement effective measures to protect residents, and relied on a volunteer to monitor residents during an activity involving resident #010 who has a history of an identified responsive behaviour, a referral to the Director will be made.

In addition, the severity is potential harm and the scope is isolated. The previous history is significant as follows:
• Inspection #2016_321501_0019: An immediate order was served on September 25, 2016, related to resident #010's abuse of seven residents. A compliance order was also issued on November 16, 2016.
• Inspection report # 2017_626501_0004: Another compliance order was issued March 9, 2017 related to resident #010's continued abuse.
(501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the staffing plan provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

The plan will include, at a minimum, the following elements:
1. A documented monitoring system to ensure that all residents within the home receive at a minimum two baths/showers twice a week by method of his/her choice.
2. The Director will be notified in writing if and when there is a period of staff shortage exceeding 37.5 hours each week.

Please submit the plan to Julieann.hing@ontario.ca no later than October 30, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provide for a staffing

mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

A complaint was submitted to the MOHLTC in June 2017, alleging the home has been scheduling agency staff to work instead of calling in the regular PSW staff as needed. The complainant reported to the inspector in July 2017, there is PSW staff shortage on home areas and staff were not being replaced when ill and no baths/showers are being provided to the residents.

PSW #125 approached inspectors #501 and #649 in July 2017, and stated the home is short staffed and baths/showers are not being provided to the residents. According to PSW #125 PSWs are being called in to start their day shift earlier than their scheduled start time.

Interview with resident #021 in July 2017, revealed that he/she was scheduled to have a tub bath that day and had not received one for several weeks which makes him/her feel dirty. The resident told the inspector that the reason he/she has not been receiving a tub bath is because the home is short of PSW staff. Review of resident #021's documentation of baths for an identified period in July 2017, indicated no evidence that the resident received baths on two identified days in July 2017. According to the progress notes no baths were done on these two identified days because the home was short staffed.

Interview with resident #029 in July 2017, revealed that he/she is scheduled to have a shower on Mondays and Thursdays and told the inspector that he/she did not have his/her shower today and has not had his/her hair washed since the previous Monday. The resident revealed that he/she feels annoyed and self-conscious and thinks the other residents can smell him/her. The resident told the inspector that he/she reported this concern to staff in the office and was told that it has nothing to do with them in the office and to speak with the staff on the floor. The resident reported that he/she had already spoken with staff on the floor and still is not able to get his/her scheduled shower. Review of resident #029's documentation of showers for an identified period in July 2017, indicated no evidence that the resident received a shower on an identified day in July. According to the progress note no shower was not done on this day because the home was short staffed.

Interview with resident #030 in July 2017, revealed that he/she is scheduled to have his/her shower on Mondays and Thursdays and told the inspector that

he/she did not have his/her shower today because the home was short staffed and the staff did not have the time. The resident stated that the home is always short and a few days ago there were only two PSWs on floor instead of the scheduled four PSWs. The resident stated that he/she had a good wash but it is not the same as a shower and he/she did not get his/her hair washed. The resident told the inspector he/she feels angry and upset when he/she does not get a shower which helps to wake him/her up and makes him/her feels fresh. According to the resident summers are the worst because of staff vacation and the home cannot seem to fill the shifts and does not think there has been a summer since he/she had been there where the home had been fully staffed. The resident has been living at the home for almost four years. Review of resident #030's documentation of showers for an identified period in July 2017, indicated the resident did not receive a shower on an identified day in July 2017. According to a progress note no shower was done on this day because the home was short staffed.

Interviews with RPN #108 and #112 in July 2017, revealed that the home is short PSW staff every shift. According to RPN #108 the staff on modified duties are not being replaced and have to come to work and the residents do not get their baths/showers. RPN #112 revealed when there are only two staff working on the floor and have to perform a lift that requires two staff they are unable to respond promptly to other residents' call bells.

A review of the PSW staffing hours for the period of April through mid-August 2017, revealed a significant amount of PSW hours were short in the home.

Interview with PSW #132 in July 2017, revealed that staff are stressed and frustrated from constantly working short staffed. There are frequent staff call-ins and there is a high turnover of staff within the home. According to the PSW the staffing shortage is getting progressively worse. PSW #132 is concerned that residents are being neglected as they have to wait for care such as toileting when the home is short staffed.

Interview with the DOC revealed there is a PSW shortage within the home and residents probably on certain days, have not received the care they need. The DOC stated he/she is trying to hire more PSW staff but it is a challenge. The DOC further revealed that he/she had evaluated the 2017 staffing plan and made a decision to approach another staffing agency.

Interview with the Administrator and ADOC revealed that the home is not meeting the residents' assessed care needs given the high number of PSW staff shortage and reported that this has been happening since January 2017.

Due to the increase in staffing shortage during an identified period resulted in residents not receiving his/her baths/showers twice weekly, a referral to the Director is being made.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as widespread. Review of the home's compliance history revealed that a written notification (WN) and voluntary plan of correction (VPC) were issued on March 9, 2017, under inspection report #2017_626501_0004 for non-compliance with LTCHA, 2007 O. Reg. 79/10, r. 31. (3). Due to the severity of potential for actual harm and previous non-compliance with a VPC a director referral (DR) is warranted.
(649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

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 25th day of September, 2017

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 : JulieAnn Hing

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