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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2015	2015_380593_0012	S-000730-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

ROSEVIEW MANOR
99 SHUNIAH STREET THUNDER BAY ON P7A 2Z2

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

GILLIAN CHAMBERLIN (593), BEVERLEY GELLERT (597), DEBBIE WARPULA (577), JENNIFER KOSS (616)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 4, 5, 6, 7, 11, 12, 13, 14 and 15, 2015

The following logs were also inspected:
S-000321-14
S-000332-14
S-000399-14
S-000403-14
S-000524-14
S-000546-14
S-000641-15
S-000642-15
S-000654-15
S-000666-15
S-000693-15
S-000697-15
S-000772-15
S-000773-15
S-000856-15
S-000861-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Social Worker, Environmental Services Manager, Dietary Aides, Food Services Manager, Registered Dietitian, Housekeeping staff and the Recreation Manager.

The inspectors also completed observations of residents and resident care, reviewed health care records and interviewed residents and their families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **16 WN(s)**
- **7 VPC(s)**
- **2 CO(s)**
- **0 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
O.Reg 79/10 s. 129. (1)	CO #002	2014_333577_0008	616
O.Reg 79/10 s. 50. (2)	CO #001	2014_333577_0008	597

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from sexual abuse by resident #022.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #022 towards resident #017. The incident was reported by resident #017 and it was reported that this was non-consensual.

A CI was submitted to the MOHLTC in relation to a second incident of reported abuse by resident #022 toward resident #018. It was reported by a staff member that they found resident #022 in resident #018's room when the incident occurred and resident #018 was not cognitively aware however this incident was considered non-consensual.

A CI was submitted to the MOHLTC in relation to two incidents of reported abuse by resident #022 toward residents #019 and #023. It was reported by staff that resident #022 was found in resident #023's room at the time of the incident. Later that same night, staff reported that resident #022 was found in resident #019's room.

During an interview with Inspector #593 May 13, 2015, S#114 reported that two of the incidents of abuse towards residents #017 and #018 by resident #022 were reported to them after they occurred. They further advised that after these two incidents, increased staffing for resident #022 was initiated, however there continued to be further incidents of abuse by resident #022 toward other residents in the home including residents #019 and #023.

During an interview with Inspector #593 May 15, 2015, the DOC advised that resident #022's behaviours have been difficult to manage and that is why they initiated increased staffing for this resident. The DOC further added that they really had to speak to PSWs about their role when providing additional care for resident #022, as initially when they were with resident #022, they would leave resident #022 to help their co-workers.

A review of the guidelines for staff when providing additional care to resident #022 found

a list of strategies for monitoring this resident and preventing further occurrence of abuse.

A review of resident #022's health care record found documentation related to dementia observation system (DOS) charting commencing the date of the first incident of reported abuse towards a resident in the home. The DOS charting continued daily for approximately two months and during this period five additional incidents of abuse occurred by resident #022 toward multiple residents in the home. Numerous gaps were found in the DOS documentation during this period. During an interview with Inspector #593 May 15, 2015, the DOC advised that the DOS charting was being completed 24/7 and that any gaps would be related to non-charting.

A review of resident #022's health care record found a referral for a behavioural specialist dated several days before the first incident occurred. After the assessment was completed by the behavioural specialist, the assessment indicated the following: Writer reviewed the documentation and noted that there was documentation of the resident displaying responsive behaviours toward staff in the home for approximately the next six months.

Shortly after resident #022 was referred to the behavioural specialist, the specific responsive behaviours were witnessed toward residents in the home with multiple incidents of abuse being reported. A review of resident #022's progress notes showed a timeline of incidents of abuse and specific responsive behaviours towards residents in the home:

Progress Note 1
RPN at 2000h reported that resident #022 abused resident #023 while in a conmmon area at 1950h as per residents report. Resident also stated that they pushed the resident away. ADOC informed at 2025h and would like staff to monitor the resident regularly.

Progress Note 2
RN informed writer at 1920h that a resident informed them that a resident abused them. Increased staffing at present for the resident.

Progress Note 3
It was brought to this RN's attention by a PSW that resident #022 apparently entered resident #017's room either last evening or during the night shift and was reported to have abused resident #017. Resident #017 had apparently screamed at resident and told

them to leave the room.

Progress Note 4
PSW reported that resident #022 found in resident #018's room. PSW reported that resident #022 was abusing resident #018. RN aware of resident behaviour, more frequent checks during the night. ADOC was informed at 0745h and has requested additional monitoring of the resident.

Progress Note 5
Staff knew resident #022 was in the dining room when they started to do personal care on several other residents. Once finished, resident #022 was no longer in the dining room. Staff started to search unit and found resident #022 in another residents room.

Progress Note 6
Multiple incidents occurred overnight. Additional staffing in place immediately as soon as the writer made aware of incidents by PSW. Additional staffing in place for resident until further notice as per ADOC. Night PSW found resident #022 trying to move resident #023's bedside table, and displaying specific responsive behaviours towards the resident. The night PSW also reported that resident #022 was displaying specific responsive behaviours towards another resident.

The CI that was submitted for the sexual abuse incident toward female resident #017, documented that resident #017 was visibly upset by the incident and as a result, several interventions were put in place to help the resident feel safe. This was confirmed during an interview with the Administrator May 12, 2015, who reported that resident #017 was concerned and affected by the incident and as a result of the incident, located to another room within the home on a different level to resident #022. Observations during the RQI, found that the resident still has the interventions in place to help them feel safe.

A review of resident #017's care plan, found a safety related focus and interventions relating to this.

Furthermore, it was found that the first two incidents of abuse towards two residents in the home were not reported to the Director of the Ministry of Health and Long-Term Care as per the 2007 LTCHA which states that abuse of a resident by anyone that resulted in harm or a risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

As evidenced by documented progress notes and staff interviews, resident #022 was known to display abusive behaviours towards residents in the home. Furthermore, after the first incident occurred with resident #023; five additional incidents of abuse were allowed to occur toward numerous residents in the home including at times when it was reported that the resident had interventions in place to monitor the resident. As reported, this has resulted in a resident requiring significant interventions to feel safe. The licensee has failed to protect residents within the home from resident #022 with known and documented inappropriate behaviours. [s. 19. (1)]

2. The licensee has failed to protect residents from verbal abuse by S#115.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to an incident of reported verbal abuse by S#115 toward resident #021. It was reported by S#116 that the resident requested assistance, S#115 then approached the resident and was verbally abusive toward the resident while providing assistance.

Under O.Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

During an interview with Inspector #593 May 12, 2015, S#117 advised that they witnessed the incident of verbal abuse toward resident #021 by S#115. They reported that S#115 was very rude to the resident, rushing them and being verbally abusive toward the resident as S#115 was providing assistance to the resident. S#117 reported that there was a prior incident where S#115 was not pleasant toward a resident however they can no longer remember the exact details.

During an interview with Inspector #593 May 14, 2015, S#116 reported that they witnessed the incident of verbal abuse toward resident #021 by S#115. They reported that S#115 yelled to the resident and was verbally abusive toward the resident. S#116 reported this immediately and S#115 was taken off the floor. S#116 further advised that this incident was not isolated, and that S#115 had done this before and generally their behaviour was not acceptable towards residents.

S#116 advised that the incident happened on a Tuesday and S#115 was sent home pending the investigation the same day, however S#115 returned the following weekend

as they were short staffed and S#115 worked both the Saturday and Sunday evening shifts.

During an interview with inspector #593 on May 14, 2015, S#118 reported that prior to the incident with resident #021, they witnessed the same resident standing in their doorway waiting for assistance from staff. S#118 saw S#115 yell very rudely at the resident when the resident requested assistance from the staff member. S#118 thought it was inappropriate but did not report it further. They also added that there was another incident where S#115 had said something to a resident, they cannot remember exactly what was said but made them think that it could have been considered abuse. At the time, S#118 said to S#115 that they should really be careful with what they say to residents in the home.

A review of the home's policy LP-C-20-ON Resident Non-Abuse-Ontario dated September 2014 found that any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information upon which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the homes reporting requirements to ensure that the information is provided to the ED immediately. The home failed to ensure that their policy to promote the prevention of abuse and neglect is complied with as S#118 did not report to the ED or the most senior supervisor on shift at that time, the abuse toward a resident that they witnessed.

As witnessed by multiple staff members within the home, S#115 was verbally abusive towards residents on numerous occasions. It was reported by several staff members that prior incidents had occurred. As such, the licensee has failed to protect residents from abuse by a staff member in the home. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of, a between meal beverage in the morning and afternoon.

On May 8, 2015, Inspector #593 observed that no nourishment pass was undertaken in one of the units of the home. Inspector #593 observed between 1030 hrs and 1130 hrs in this area and observed that none of the residents in this unit were offered or provided a beverage during this time. A cart was observed in the kitchenette during this time which contained a variety of beverages. This cart was not touched by a staff member during these observations. Inspector #593 observed the posted time for the AM nourishment part in this unit was 1030 hrs. At 1130 hrs, the Inspector observed staff starting to set the dining room up for lunch including bringing residents into the dining room to be seated.

On May 11, 2015, at 1410 hrs, Inspector #593 observed S#101 provide beverages to three of the four residents in the common area of one of the home's units. The inspector observed this area from 1400 hrs until 1500 hrs and observed no other residents in this unit offered a beverage. The inspector observed 15 residents in this unit who were not provided or offered a beverage during this time. The posted PM nourishment time in this unit was 1400 hrs. A cart was observed in the kitchenette during this time which contained a variety of beverages. At 1500 hrs shift changeover was underway.

On May 13, 2015, at 1040 hrs, Inspector #593 observed two residents seated in the common area of one of the home's units who were provided a beverage. There were five other residents in this area who were not offered or provided a beverage at this time. Inspector #593 observed this area from 1025 hrs until 1130 hrs and observed that no other resident in the unit was provided or offered a beverage. The posted time in this unit for the AM nourishment pass was observed to be 1030 hrs. There were at least 21 residents in this unit during this time period that were not offered an AM beverage. A cart

was observed in the kitchenette during this time which contained a variety of beverages. During the period of observation, the beverage care was accessed only once by a staff member who poured themself a juice however provided no beverages to any residents.

During an interview with Inspector #593 on May 14, 2015, the Nutrition Manager S#122 reported that the homes expectation for the AM and PM nourishment pass is that the dietary staff are to set up the carts with beverages and/or snacks and leave them in the kitchenette or dining room of each unit in time for the nourishment pass. The expectation is that the PSW who has been assigned that role that day will take the cart and offer/provide nourishment to the residents. They did further report that they have had issues in the past with the provision of between meal nourishments.

During an interview with Inspector #593 on May 14, 2015, the DOC confirmed that a PSW is assigned the nourishment pass in each of the home's unit. It is their responsibility to ensure that this is completed. The DOC further reported that they have had a lot of trouble with the nourishment pass being completed.

A review of the home's Policy: LTC-G-130 Between Meal Nourishments, dated December 2014, found that Between meal nourishments will be provided to residents according to provincial regulations and residents' quality of life will be enhanced and nutrient requirements met through the provision of between meal nourishments. [s. 71. (3) (b)]

2. The licensee has failed to ensure that each resident is offered a minimum of, a snack in the afternoon.

Inspector #593 on May 11, 2015, observed at 1410 hrs S#101 provide three of the four residents in the common area of one of the home's units a beverage. These residents were not provided or offered a snack. The inspector observed this area from 1400 hrs until 1500 hrs and observed no other residents in this unit offered a snack. The inspector observed 15 residents in this unit who were not provided or offered a snack during this time. The posted PM nourishment time in this unit is 1400 hrs. A cart was observed in the kitchenette during this time which contained only a variety of beverages. At 1500 hrs shift changeover was underway.

During an interview with Inspector #593 on May 14, 2015, the Nutrition Manager S#122 reported that the homes expectation for the AM and PM nourishment pass is that the dietary staff are to set up the carts with beverages and/or snacks and leave them in the

kitchenette or dining room of each unit in time for the nourishment pass. The expectation is that the PSW who has been assigned that role that day will take the cart and offer/provide nourishment to the residents. They did further report that they have had issues in the past with the provision of between meal nourishments.

During an interview with Inspector #593 on May 14, 2015, the DOC confirmed that a PSW is assigned the nourishment pass in each of the home's unit. It is their responsibility to ensure that this is completed. The DOC further reported that they have had a lot of trouble with the nourishment pass being completed and that is why they started to assign a PSW to the task, to put the responsibility on them.

A review of the home's Policy: LTC-G-130 Between Meal Nourishments, dated December 2014, found that Between meal nourishments will be provided to residents according to provincial regulations and residents' quality of life will be enhanced and nutrient requirements met through the provision of between meal nourishments.

As a result of reviewing the severity and scope of the incident and the licensees' compliance history, the inspector identified that a compliance order was warranted. The severity of the incident was identified as minimal harm or potential for harm, the scope level was identified as pattern as multiple residents on two home areas were observed not to have been offered a between meal or evening beverage and / or a snack in the evening. The compliance history indicated that the licensee has had previous related non-compliance. O. Reg. 709/10. s. 71 (3). [s. 71. (3) (c)]

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

On May 12, 2015, Inspector #577 met with the ADOC regarding the home's staffing plan. The ADOC reported that the home schedules PSWs as follows:

Heritage Unit has 2 PSWs on day and evening shift plus 1 from 1500-1930hr.
Champlain Unit has 2 PSWs on day and evening shift plus 1 from 1500-1930hr, an additional PSW works from 0730-1200hr and is shared between Heritage and Champlain.
Celeste Unit has 3 PSWs on day and evening shift.
Primrose Unit has 3 PSWs day and evening shift.
Cheshire Unit has 2 PSWs on day and evening shift plus 1 from 0730-1200hr.
Renaissance Unit has 2 PSWs on days and evenings plus 1 from 0730-1200hr.

The ADOC reported that in the event that they are short on a day shift, they will pull 1 PSW from Celeste or Primrose Unit to the area that is short. The plan is that bathing will not be done if short staffed. The contingency plan report is completed by the Registered Nurse, and the PSWs report to the RN if baths were missed. The form is placed in a staffing binder and given to the Staffing Coordinator. The staffing plan indicates that in the event of PSW shortages, they are to call all available PSW/HCA, bring staff in early or stay late, reassign staff, reassign residents to available PSWs and call the agency.

The inspector reviewed the home's memo 'PSW Contingency Report' dated April 17, 2014. The memo indicated that the plan is based on the event when they are unable to replace PSW sick calls. It is expected that residents will be provided with basic needs including nourishment, toileting and basic cleanliness. A PSW contingency plan report is filled out by the RN and submitted to scheduler and the DOC for follow-up on resident

care. A bath team will be organized the next day to accommodate missed resident baths.

On May 13, 2015, Inspector #577 received and reviewed the master staffing schedule for nursing and PSW's. The following staffing shortages from April 10-May 10, 2015 were identified:

April 10-short 1 four hour evening (PSW)
April 11-short 1 day shift, 1 four hour evening (PSW)
April12-short 1 day shift, 1 four hour day, 1 evening shift, 1 night shift (PSW)
April 13-short 1 day shift, 1 evening shift (PSW)
April 14-short 1 day shift, 1 four hour evening (PSW)
April 15-short 1 four hour day shift, 1 four hour evening shift (PSW)
April 16-short 1 day shift, 1 evening shift (PSW)
April 17-short 1 evening shift, 1 night shift (PSW)
April 18-1 four hour evening (PSW), 1 full evening (RPN)
April 19-2 day shifts, 2 four hour days (PSW), 1 day (RPN), 1 night 7-7am (RPN)
April 20-1 day shift, 2 four hour days (PSW), 1 night 7-7am (RPN)
April 21-2 four hour days, 1 day (RPN), 1 four hour evening (PSW)
April 23-1 day shift, 1 four hour day, 1 evening (PSW)
April 24-1 four hour day, 1 night (PSW)
April 25-2 day shifts, 2 four hour shifts, 1 evening shift (PSW)
April 26-1 day shift, 1 four hour shift, 1 evening shift, 1 four hour evening shift (PSW)
April 30-1 four hour day shift (PSW)
May 2-1 day shift, 2 four hour shifts (PSW)
May 3-2 four hour shifts (PSW)
May 4-1 day shift, 2 four hour shifts, 1 four hour evening, 1 night (PSW)
May 6-1 day (PSW)
May 7-1 day shift (PSW)
May 8-1 four hour evening (PSW)
May 9-1 four hour day, 1 four hour evening (PSW)
May 10-1 day shift (PSW)

On May 13, 2015, the ADOC provided the Inspector with the PSW Contingency Reports that were completed for two days in May, 2015, where the home was short staffed.
Day One: baths were not done or completed on another day for nine residents.
Day two: baths were not done or completed on another day for twelve residents.

All missed baths were confirmed by the ADOC.

As a result of short staffing, 21 residents did not receive their baths on two days in May or completed on another day that week. [s. 8. (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 an organized program of nursing and personal support services for the home is in place to meet the needs of the residents, to be implemented voluntarily.

WN #4: 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 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.

Inspector #597 interviewed S#104 regarding bed system assessment that takes into consideration all potential zones of entrapment. S#104 reports that they have completed training and the home has purchased the assessment tools, however the bed assessments have not been completed on all beds.

S#104 was interviewed by Inspector #597 on May 14, 2017. They reported that rail height and latch reliability are not regularly evaluated as preventative maintenance. If nursing staff are concerned with a bed rail, they will enter a work order and maintenance will address as soon as possible. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that where bed rails are used, the 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During stage one of the RQI, it was observed by Inspectors #593 and #597 that multiple resident bedside call systems were not functioning.

On May 4, 2015, the call system in room A was tested by Inspector #593 and found that the system was not functioning and a call was not successfully placed. At this time, the resident advised that it has not been working for a few days and this is a problem for them as they need to call regularly for assistance.

On May 6, 2015, the call system in room A was tested by Inspector #597 and found that the system was not functioning and a call was not successfully placed.

On May 6, 2015, the call system in washroom B was tested by Inspector #593 and found that the system was not functioning and a call was not successfully placed.

Additional call system checks were undertaken by Inspector #593 on May 14, 2015:

• Room C- the call system was tested by Inspector #593 three consecutive times. The dome light in the hallway did not illuminate and a call was not successfully placed.

• Room D- the call system was tested by Inspector #593 three consecutive times. The dome light in the hallway did not illuminate and a call was not successfully placed.

• Room E- the pull cord on the call system in the resident's washroom was observed to be broken.

• Room F- after placing a call, the button was stuck down and the call was unable to be cancelled nor were further calls able to be placed. The button had to be pried out for the system to be functioning correctly.

• Room G- the pull cord was jammed under the bed wheel and up inside the bedside drawer. The button to place a call was unable to be located and therefore a call was unable to be placed.

• Room E- the call system was tested by Inspector #593 three consecutive times. The dome light in the hallway did not illuminate and a call was not successfully placed.

During an interview with Inspector #593 on May 14, 2015, S#104 advised that the resident call system is not part of the preventative maintenance system and the system is not tested on a regular basis. S#104 further added that it is up to the front line staff to report if a call system is not functioning however complete records are not kept for the call systems that are reported as not functioning or in disrepair.

A review of the home's policy ESP-B-95 'Other Equipment Preventative Maintenance Program 'dated September 2004, found that all equipment will be monitored through the preventative maintenance program including Nurse Call Systems which are to be monitored by environmental services on a quarterly basis to ensure proper functioning and maintenance. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that call bells are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During an internal investigation into an abuse allegation toward a resident by S#119, it was revealed by S#120 that a prior incident of alleged abuse had also occurred by S#119. S#120 reported that S#119 was verbally abusive toward a resident. This was reported to have occurred in the dining room full of residents seated for lunch. S#120 did not report this to the home until 10 days after the incident occurred.

During an interview with Inspector #593 on May 12, 2015, the Administrator advised that S#120 did not come forward regarding the incident at the time it occurred, as they had pulled S#119 aside and corrected their behaviour at the time of the incident.

It was reported by a family member to the ADOC that S#121 left resident #005 without care required. Resident #005 had to ask S#103 for assistance with this care after S#121 left. During an interview with Inspector #593 on May 12, 2015, S#103 confirmed that the resident had called them over and asked them for assistance with finishing care. S#103 advised that they did not report it further as the resident told them that they were calling their son, who was going to report it to the home.

During an interview with Inspector #593 on May 12, 2015, the Administrator advised that S#121 left the resident without finishing care but did not inform another staff member that the resident needed care to be finished. The resident was in the door way of their room and flagged down S#103 to provide assistance. The administrator confirmed that the family member reported the incident to the ADOC three days after it occurred and S#103 did not report this incident further.

During an interview with Inspector #593 on May 14, 2015, regarding an incident of staff to resident abuse, S#118 reported that prior to the incident of verbal abuse from S#115 toward resident #021, they witnessed the same resident standing in their doorway, S#118 saw S#115 yell very rudely at the resident. S#118 thought it was inappropriate but did not report it further. S#118 also reported that there was another incident where S#115 had said something to a resident, but cannot remember exactly what they said but think that it could have been considered abuse, at the time, S#118 said to S#115 "they should really be careful about what they say". Neither incident was reported further by S#118.

A review of the home's policy LP-C-20-ON Resident Non-Abuse-Ontario dated September 2014 found that any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information upon which it is based to the ED of the home or, if unavailable, to the most senior supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the homes reporting requirements to ensure that the information is provided to the ED immediately.

The home failed to ensure that their policy to promote the prevention of abuse and neglect is complied with as neither S#118 nor S#103 reported the abuse that they

witnessed. [s. 20. (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 the home's policy to promote zero tolerance is complied with by all staff., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.

The Ministry of Health and Long Term Care (MOHLTC) After Hours Pager was first notified of an incident reporting allegations of staff to resident(s) abuse which occurred five days earlier. A Critical Incident (CI) report followed to the Ministry of Health and Long Term Care (MOHLTC) two days later.

An interview was conducted with the DOC on May 11, 2015, at 1608 hrs to discuss reporting requirements. The DOC acknowledged the report was not submitted immediately as required, stating the investigation had been initiated immediately but the home could not prove the allegations at that time. [s. 24. (1)]

2. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported verbal abuse by S#119 toward resident #004. It was reported by S#120 that S#119 was verbally abusive to resident #004. This was reported to have occurred in the dining room full of residents seated for lunch.

The CI was submitted however, the incident actually occurred more than a month earlier than when the CI was reported to the MOHLTC.

During an interview with Inspector #593 on May 12, 2015, the Administrator advised that S#120 did not come forward regarding the incident at the time it occurred, as they had pulled S#119 aside and corrected their behaviour at the time of the incident. S#120 reported the incident 10 days after it occurred. The Administrator advised that they did not report it to the MOHLTC until three weeks after they were aware as an inspection into a different incident of resident abuse prompted them to report this incident to the MOHLTC.

A CI was submitted to the MOHLTC in relation to reported neglect by S#121 toward resident #005 in the home. It was reported that the S#121 left resident #005 without care. The resident had to flag down another staff to assist in finishing care.

The CI was submitted however, the incident actually occurred three days earlier than when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC in relation to reported abuse by a newly admitted resident toward five residents in the home. It was reported that the resident was going into other resident rooms and abusing them.

The CI was submitted however, the first incident actually occurred three days earlier than

when the CI was reported to the MOHLTC.

A CI was submitted to the MOHLTC in relation to reported neglect by a PSW towards several residents in the home. A PSW and RPN coming onto day shift reported that the night shift PSW left five residents without care.

The CI was submitted however the incident actually occurred four days earlier than when the CI was reported to the MOHLTC.

During an interview with Inspector #593 May 12, 2015, the Administrator advised that the neglect allegations were reported to them by the RPN via e-mail. The Administrator advised that the reason the CI was reported late was probably due to the holidays.

A record review of resident #022's progress notes found an additional two incidents of abuse by resident #022 toward two residents in the home. One- it was reported by a resident that resident #022 abused them. Two- it was reported by resident #023 that resident #022 abused them. Resident #023 also stated that they pushed resident #022 away. Neither incident was reported to the Director.

The licensee submitted four critical incident reports over a six month period involving abuse and neglect towards residents in the home by other residents and staff members. On all four occasions, the CI was reported between three days to one month after the incident occurred. Furthermore, two incidents of resident to resident abuse were not reported to the Director. As such, the licensee has failed to immediately report the abuse of a resident and the information upon which it is based to the Director. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #8: 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 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).

On May 14, 2015, Inspector #577 discovered during a record review, that Resident #045 had a witnessed fall. Progress notes indicated that resident was ambulating without their ambulation assistance in a home area, tripped over and stumbled to the floor, suffering an injury. Additionally, the resident had a witnessed fall in another home area, where they lost their balance. Progress notes indicate that resident was able to pull themself up with the wall railing.

On May 15, 2015, Inspector #577 reviewed the home's policy on 'Falls Interventions Risk Management Program', revised date March 2014. The policy indicated that documentation post fall includes resident care plan, progress notes, neurological monitoring documentation, adverse event tracking form, resident incident internal report for all falls and updated high risk profile. Inspector spoke with DOC and ADOC, who both confirmed that the home's post-fall assessment clinical instrument utilized is the 'Resident Fall Documentation' form, and it is to be completed after every fall.

Through record review, Inspector did not find a completed Resident Fall Documentation form for either of the resident's falls. On July 2, 2015, Inspector spoke with the ADOC, who further reported that the post fall assessment, Resident Fall Documentation, was not completed post fall for either fall.[s. 49. (2)]

2. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and if required, a post fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint was received by the MOHLTC, from the SDM of resident #030. The SDM reported that the resident was at a high risk for falls prior to admission and had experienced five falls since admission. After the five falls had occurred, the resident fell again and sustained a serious injury. The SDM reported that the home has not implemented any interventions to prevent the resident from falling.

The health care record for resident #030 was reviewed by Inspector #597. Resident Fall Documentation records were initiated for all six falls, however the interventions to prevent fall reoccurrence were not completed on four of the six assessments. [s. 49. (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 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, for all residents and specifically regarding residents #030 and #045, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

On May 11, 2015, Inspector reviewed resident #044's health care record concerning their continence. Resident was admitted to the home in 2013, and the continence assessment indicated that resident was continent. Current MDS data for indicated that the resident indicates that this has changed related to several factors and the resident requires certain interventions to manage their continence.

On May 13, 2015, Inspector reviewed home's policy 'Continence Care', revision date 2013. The policy indicated that staff are to initiate a 3 day continence assessment on admission and/or if there is a change in their level of continence. Inspector spoke with the ADOC, who confirmed that the home's clinically appropriate assessment instrument for assessment of incontinence is the three day continence assessment. They further confirmed that the three day continence assessment was not completed for this resident on admission and/or when there was a change in continence. No continence assessment was found that was completed when the resident's condition changed and they became incontinent.[s. 51. (2) (a)]

2. The licensee has failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

On May 11, 2015, Inspector reviewed resident #066's health care record concerning their continence. Resident was admitted to the home in 2014, and the continence assessment was not completed.

On May 13, 2015, the inspector reviewed home's policy 'Continence Care', revision date 2013. The policy indicated that staff were to initiate a three day continence assessment on admission and/or if there was a change in their level of continence. Inspector spoke with the ADOC, who confirmed that the home's clinically appropriate assessment instrument for assessment of incontinence is the three day continence assessment. They further confirmed that the three day continence assessment was not completed for this resident on admission. No continence assessment completed at admission or at anytime since admission, was found for this resident. Resident's current care plan indicates the resident is incontinent.

S#123 reported to inspector that the resident has been incontinent for approximately six months. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, for all residents but specifically regarding resident #066 and #044, to be implemented voluntarily.

WN #10: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

that sets out clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

A Critical Incident (CI) report was received by the Ministry of Health and Long Term Care (MOHLTC). The report indicated that resident #045 was admitted to acute care for a serious injury, of unknown cause.

On May 14, 2015, Inspector #577 reviewed the resident's care plan after hospitalization. Under focus of 'Locomotion on unit', care plan indicated interventions related to the sustained injury. The clinic report, indicated a two week follow-up after treatment for the sustained injury.

The care plan did not provide clear description of the location of the resident's injury. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #025 provided clear direction to staff and other who provide direct care to the resident. 2007, c. 8, s. 6 (1).

The current care plan for resident #025 was reviewed by Inspector #597. The care plan identified resident #025 as a high fall risk but did not mention the safety intervention of a device to be applied.

On a day in May, 2015, the resident was observed sitting in the dining room with the safety device applied. The resident was attempting to rise to a standing position and was reminded by staff to remain seated. The resident was also observed to be seated with the safety device applied on three other days in May, 2015.

The inspector interviewed S#101 who reported that the safety device is to be done up when the resident is seated and that the resident is able to release the safety device on their own. On May 14, 2015, S#102 and S#103 reported that a safety device was in use for resident #025 but it was not considered a restraint. The safety device is in use to remind resident not to reach or stand.

The ADOC was interviewed on May 15, 2015, and reported that all safety devices should be included in care plan as per Least Restraint Policy LTC-K-10.

The care plan for resident #025 did not mention the use of a safety device.[s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care for resident #029 provided clear direction to staff and other who provide direct care to the resident.

The current care plan for resident #029 was reviewed by Inspector #597. The care plan identified resident #029 as a high fall risk but did not mention the use of a safety device to be applied while seated as an intervention.

On a day in May, 2015, the resident was observed eating lunch in the dining room with the safety device applied. The resident was observed to be seated with the safety device applied on another occasion. The resident was observed seated with the safety device released and hanging at the sides of the chair on two other days in May, 2015.

The inspector interviewed S#103 who reported that the safety device was to be done up but the resident was able to release the safety device to use the washroom. On May 14, 2015, S#102 reported that a safety device was in use for resident #029 but was not considered a restraint as the resident was able to release the safety device. S#101 reported that the resident does not need the safety device applied and it is up to the resident to use it. It was also reported by S#101 that the resident is forgetful. S#107 reported to the inspector that they do not know if the resident's safety device should be applied as they are a new employee.

Resident #029 was interviewed and reported that they are able to release the safety device, but that the staff tell them that they are not supposed to.

The ADOC was interviewed on May 15, 2015, and reported that safety devices should be included in care plan as per Least Restraint Policy LTC-K-10.

The care plan for resident #029 did not provide clear direction regarding the use of the safety device. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there is a written plan of care for resident #029 that sets out clear directions to staff and others who provide direct care to the resident. s. 6. (1) (c)

The current care plan for resident #029 with printed date of May 7, 2015 indicated that the resident requires support for oral hygiene. There are multiple interventions related to oral care documented in the residents care plan.

S#101 was interviewed on May 8, 2015, and reported that the resident does requires certain interventions for mouth care.

The care plan for resident #029 does not provide clear direction on the oral hygiene support that they require. [s. 6. (1) (c)]

5. The licensee has failed to 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).

On May 13, 2015, S#108 reported that resident #066 required additional staffing as a result of an incident of social inappropriateness which occurred with a co-resident. S#109 confirmed additional support was initiated by the Director of Care after the incident, as per resident #066's progress notes.

A review of resident #066's care plan related to Responsive Behaviours listed the additional support as a required intervention.

S#109 presented a binder found at the nursing station for resident #066's additional support and reported that it was the responsibility of the PSW assigned complete the flow sheets.

The administrator was interviewed on May 13, 2015, and confirmed that the additional support was initiated for resident #066 after an incident that involved a co-resident. They stated that the additional support was scheduled for all shifts including days, evenings, and nights. The administrator reported there may be times where the shift coverage could not be provided by nursing staff, and the home will utilized other departments such as housekeeping staff.

The flow sheets were reviewed by the inspector and it was noted that the documentation was incomplete. The additional support was initiated, however there were no flow sheets observed until four days later. In addition, 32 days had missing documentation throughout the 24 hour period.

In conclusion, the flow sheets were not completed for resident #066 as indicated in the plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that resident #002's care as set out in the care plan is provided to the resident as specified in the plan.

A review of resident #002's care plan dated April 20, 2015, found that the resident was to receive a dietary intervention at mealtimes. This was also confirmed in the physician's orders. This order has been in effect for six months.

During the lunch meal service on a day in May, 2015, Inspector #593 observed resident #002 provided a regular meal. The resident was not provided the required dietary intervention. During the lunch meal service on another day in May, 2015, Inspector #593 observed resident #002 provided a regular meal. The resident was not provided the required dietary intervention.

During an interview with Inspector #593 on May 8, 2015, S#110 advised that resident #002 receives a regular meal, and that they do not receive any dietary interventions.

During an interview with Inspector #593 on May 8, 2015, S#111 advised that resident #002 does not have any special nutrition requirements at mealtimes and the resident receives a regular meal.

During an interview with Inspector #593 on May 11, 2015, S#112 advised that resident #002 does not have any special dietary requirements and they receive a regular meal.

During an interview with Inspector #593 May 15, 2015, S#113, Registered Dietitian, advised that resident #002 is still required to receive the dietary intervention. This intervention was implemented to assist in improving the resident's nutritional status.

During the inspection, resident #002 was not observed to receive the dietary intervention as per the plan of care and furthermore registered and front line staff were unaware of the dietary requirements for this resident as per the resident's plan of care. [s. 6. (7)]

7. The licensee has failed to ensure that resident #022's care as set out in the care plan is provided to the resident as specified in the plan.

A review of resident #022's current care plan, found that an intervention was implemented to monitor responsive behaviours demonstrated by this resident towards staff members and other residents in the home.

A review of the resident's documentation over a two month period, found numerous time blocks on 17 days of this period where the residents behaviour interventions were not

documented.

During an interview with Inspector #593 May 15, 2015, the DOC advised that it is the expectation that the documentation is to be completed 24/7 and they have had to completed staff education to ensure to ensure completion of this charting. [s. 6. (7)]

8. The licensee has failed to 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).

The current care plan for resident #026 was reviewed by Inspector #597. Under the focus of nutrition/eating, the interventions listed include that resident eats in a certain dining room and requires specific assistance at mealtimes.

The resident was observed in their room on a day in May, 2015. The resident was seated with a safety device applied. The chair was positioned to face out the window. The resident's lunch tray was on the bedside table to the right of the chair. The lunch tray contained a full cup of soup and a beverage on its side with the contents spilled onto the tray. The call bell was lying on the bed and out of reach of the resident. S#106 entered the room and reported that resident is allowed to eat in their room unsupervised.

The care plan for resident #026 indicated that they require certain interventions while eating, yet the resident was provided a lunch tray in their room and left unsupervised. [s. 6. (7)]

9. The licensee has failed to ensure that resident #026 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #026 was observed sitting in a chair with a safety device applied during Stage 1 of the Resident Quality Inspection.

The current care plan, indicated that the resident required the use of a device while seated and that the resident is checked every 30 minutes to ensure that the safety device is secure and that they are not attempting to transfer out of the chair. Neither the chair device or safety device are identified as a restraint or PASD.

The resident was observed in their room on a day in May, 2015. The resident was up in their chair with the safety device secured. The call bell was lying on the bed and out of

reach of the resident. As the inspector left the room the resident called out "help" and in trying to reach their lunch tray and got their elbow stuck between the side of the chair and another object.

S#106 reported that resident uses the chair device for comfort and not as a restraint and confirmed that the safety device is in use and resident could release the safety device without assistance until recently. S#106 further reported that the resident is unable to release the safety device.

The care plan for resident #026 was not updated to reflect the resident's changing care needs. [s. 6. (10) (b)]

10. The licensee has failed to ensure that resident #025 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The current care plan for resident #025 was reviewed by Inspector #597. Under the nursing focus of ambulation and cognitive function, several interventions were documented related to the mobility device.

Resident #025 was observed on four days in May, 2015, using a device for mobility. A second mobility device as listed in the plan of care was not found in the resident's room.

S#101 and S#105 were interviewed on May 8, 2015, and reported that resident #025 has not used the second mobility device since approximately six months ago. S#103 was interviewed on May 14, 2015, and also reported that this resident has not used the second mobility device for many months.

The care plan for resident #025 was not updated to reflect the resident's changing care needs. [s. 6. (10) (b)]

WN #11: 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 the policy to ensure that all equipment in the home is kept in good repair, is complied with.

During the inspection, Inspector #593 found numerous nurse-call systems in residents' rooms and washrooms that were in disrepair or not functioning as intended.

During an interview with Inspector #593 on May 14, 2015, S#104 advised that the resident call system is not part of the preventative maintenance system and the system is not tested on a regular basis. S#104 further added that it is up to care staff to report if a call system is not functioning however complete records are not kept for the call systems that are reported as not functioning or in disrepair.

A review of the home's policy ESP-B-95 'Other Equipment Preventative Maintenance Program 'dated September 2004, found that all equipment will be monitored through the preventative maintenance program including Nurse Call Systems which are to be monitored by environmental services on a quarterly basis to ensure proper functioning and maintenance. [s. 8. (1)]

2. The licensee has failed to ensure that LTC-E-90 Revera Skin and Wound Care Program with revised date of March 2014 is complied with.

A complaint was received by the MOHLTC on July 25, 2014, from the SDM of resident #030. The SDM reported that the resident was injured by another resident. The resident was admitted to hospital for a procedure and was also found to have alteration in their skin integrity.

A review of the health care record for resident #030 was conducted. A progress note described the incident where resident #030 was involved in an interaction with another resident and suffered an injury. The note entered by the registered staff indicates that the injuries were treated.

Revera Skin and Wound Care Program LTC-E-90, appendix C indicates that skin tear management is entered by the nurse on the Treatment Administration Record (e) TAR and that the nurse initials (e) TAR daily demonstrating that the injury is being monitored for any signs or symptoms of infections and ensuring dressing is intact.

The (e) TAR for resident #030 was provided to the inspector by the ADOC. Daily monitoring of the injury was not listed or signed for by the nurse. [s. 8. (1) (a),s. 8. (1) (b)]

WN #12: 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 was 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).

On May 15, 2015, the inspector interviewed the DOC who reported that there hasn't been an annual evaluation of staffing and they were unable to provide any prior records of an annual evaluation. [s. 31. (3)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A record review of Resident Council Complaint Forms dated August 5, 2014, and February 23, 2015, identified issues arising from Resident Council meetings in those respective months. The inspector noted that the response to the council on both occasions was provided at the next meeting of the Resident Council, exceeding 10 days.

On May 15, 2015, Inspector #616 met with S#126 to discuss the home's duty to respond. S#126 acknowledged responses exceed 10 days, reporting that the general practice is to present the response at the next monthly meeting. S#126 also reported that responses are not consistently received in writing. [s. 57. (2)]

WN #14: 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 has failed to ensure that the home's organized program of nutrition care and dietary services includes, a weight monitoring system to measure and record with respect to each resident, body mass index (BMI) and height upon admission and annually thereafter.

During stage 1 of the RQI, it was noted by Inspectors #593 and #597 that the recorded heights for several residents were older than one year and that many residents had not had a height measurement since admission.

A further review of the home's health care records by Inspector #593 on May 8, 2015, found the following residents had height data that were not current:

Resident #001- last height documented in 2012

Resident #002- last height documented in 2012

Resident #004- last height documented in 2015, however there was no annual height recorded in 2013 and 2014

Resident #005- last height documented in 2013

Resident #006- last height documented in 2013

Resident #007- last height documented in 2013

Resident #010- last height documented in 2012

Resident #012- last height documented in 2015, however there was no annual height recorded in 2013 and 2014

Resident #014- last height documented in 2015, however there was no annual height recorded in 2013 and 2014

Resident #015- last height documented in 2015, however there was no annual height recorded in 2012, 2013 and 2014

Resident #016- last height documented in 2010

Resident #017- last height documented in 2013

Resident #018- last height documented in 2013

Resident #019- last height documented in 2013

Resident #021- last height documented in 2012

During an interview with Inspector #593 on May 15, 2015, the home's Registered Dietitian (RD) S#113 advised that the height is supposed to be taken annually for each resident and that the BMI for each resident is calculated in the system using the most recent height data, therefore the BMI may not be entirely accurate because the heights in the system are not current.

A review of the home's Policy: LTC-G-60 Height Measurement and Weight Management, dated June 2014, found that the home will have a process in place to measure upon admission and, at minimum, annually thereafter. The procedure documents that on admission each resident's height will be measured and documented on the residents first bath day and that each residents height will be measured at a minimum annually thereafter. [s. 68. (2) (e) (ii)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and (ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

On May 11, 2015, the family of resident #061 reported to the inspector that the dining area and kitchen areas are not clean enough. Inspector #616 observed S#124 mopping the dining room floor in a Unit of the home in May, 2015 at 1005 hrs. It was noted that not all tables had been cleared of dirty dishes and resident clothing protectors. An observation of the same dining room floor was conducted at 1130 hrs noting large crumbs on otherwise clean floor. The tables were set for lunch service.

S#104 was interviewed by Inspector #616 on May 11, 2015. S#104 reported that the home has a "if you see it you clean it" policy. Reportedly all staff have access to the

housekeeping closets that are stocked with cleaning equipment and supplies. S#128 reported that housekeeping services occur daily, seven days a week, with no housekeeping staff scheduled for evenings or nights.

Observation of one of the home's dining rooms in May, 2015, at 1132 hrs was conducted by Inspector #616. Dietary staff were in the process of setting tables for lunch. The dining room floor was observed to have small amounts of crumbs/debris near table situated by the window. [s. 87. (2) (a)]

2. The licensee has failed to ensure that procedures are developed and implemented for, (a) cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces. O. Reg. 79/10, s. 87 (2).

On May 13, 2015, Inspector #593 notified Inspector #616 that droplets of a thin, brown, unidentified liquid substance was spilled in corridor near beside the nursing station and lounge. This was first observed at 1100 hrs, checked at 1505 hrs, and confirmed by Inspector #593 to remain uncleaned at 1700 hrs. On May 14, 2015, at 0807 hrs, Inspector #616 observed the dried spill as described, uncleaned. When dried spill was brought to the attention of S#104, they referred the inspector to the "slips and falls policy".

Review of the Slips and Falls Prevention – Walking and Working Surfaces (HS10-P-60, revised Jan 2015) indicated that the expectation is that "every employee has a general obligation to clean up spills, pick up debris, and take precautions to ensure Residents, staff and other persons are not injured".

The inspector observed dining room floors in three of the resident home areas between 0800-0900 hrs on May 14, 2015, before breakfast was served and noted numerous discarded paper products (Kleenex) and various packaging (sweetener) on the floor, the garbage can had overflowed with waste products, particles of food throughout the dining room floor and large toast pieces and crumbs throughout the TV lounge.

On May 14, 2015, S#129 was interviewed by the inspector and unable to provide clear direction about floor cleaning responsibility when the Dietary Aides and Environmental Services staff are off shift. S#129 further reported that they hoped if staff see something on the floor they would clean it up, especially before residents come out for breakfast. [s. 87. (2) (a)]

3. The licensee has failed to ensure that procedures are developed and implemented for, (a) cleaning of the home, including, (i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces.

On May 11, 2015, resident #064 reported that they hire a private cleaner once a week for one hour to dust, vacuum, and straighten their room as they indicated staff at the home are not able do this adequately. Resident #064 further reported that the home housekeepers still come in their room to empty the baskets, clean the toilet, sink and wipe the floor. They added they had never seen staff clean the curtains and stated they were unaware if dusting is done because it has been reported by the private cleaner, dusting is required.

When questioned on the frequency of dusting in resident rooms, S#129, stated "truthfully, only when it needs it". They reported they determine the need for dusting by just looking around. S#104 explained the expectation for room cleaning is that if dust is in the room, it should be dusted. They further reported that would be daily dusting as needed and at least once a week, including the top of the wardrobe, picture frames, table tops. They stated equipment is available to staff such as extendable dusters, and vacuums with brushes for proper cleaning. S#104 also stated they are in the process of developing an inservice as the current process may lack clarity in staff direction of their duties and responsibilities related to cleaning.

Observations of resident rooms in the following home areas on May 14, 2015:

Room A: dust observed on bedside table, window sill, fridge, lamp shade.

Room B: dust on all surfaces including window sill, television table, bedside tables, significant dust on top of wardrobe.

Room C: dust on small glass table with doilies, window sill. Significant dust observed on top of wardrobe, bedside table, and lampshade.

Room D: dust on multiple table tops throughout the room, fridge top, radio, bedside lampshade.

A record review of policies related to Housekeeping Services (ESP-C-120) General Cleaning - High Dusting (Sept. 2004) noted the frequency of cleaning to be once weekly as specified under weekly routines and/or as required. In addition, Housekeeping

Services (ESP-C-115) General Cleaning - Daily Cleaning Schedule (Sept. 2004) noted "high dusting" which S#104 explained is dusting from the top of the room progressively toward the floor.

S#104 provided records for April 2015 of the Housekeeping Tracking forms completed by staff for two home areas. The column "Dusting Rm" was specifically reviewed finding that on one of the units only a single resident room was marked as being dusted once, whereas 26 rooms had not been checked off as dusted throughout the month. On the other Unit, 15 resident rooms were checked off as dusted once in the month, with 10 resident rooms not marked as dusted at all in the 30 days. S#104 confirmed this review. [s. 87. (2) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) procedures are developed and implemented to ensure that there is a process to report and locate residents’ lost clothing and personal items; O. Reg. 79/10, s. 89 (1) (iv).

On May 11, 2015, Resident #041 and #042 both reported missing personal belongings to Inspector #593.

During a staff interview with S#127, they indicated that there is a missing item form that staff complete for missing resident belongings, and a copy of the form will be distributed to each home area, and laundry department for missing clothing.

On May 13, 2015, Inspector #577 spoke with the ADOC, who reported that staff will do a search on the home unit, complete a form, "Missing Clothing" form for missing resident property and distribute to each home area. Reports form is put on residents chart and forwarded to laundry department, activities department, ADOC and DOC.

Inspector #577 interviewed the DOC who further reported that staff are to search the area, complete a "Missing clothing" form NRC-K-70-10 for missing clothing and missing personal property and the form is forwarded to the DOC or ADOC. They further reported that they were unaware of missing personal belongings for Resident #041 and #042.

On May 12, 2015, Inspector #577 reviewed resident #041's and #042's chart and could not find a missing clothing/property form.

On May 13, 2015, Inspector #577 reviewed the home's policy, "Management of Personal Belongings", dated August 2012. The policy indicates that a Client Response Form (CQI-E-60-05) will be initiated for all missing items and a thorough search will be conducted and communicated to the resident/SDM/family.

The home failed to ensure that the process to report and locate missing items is followed. [s. 89. (1) (a)]

Issued on this 30th day of September, 2015

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593), BEVERLEY GELLERT (597), DEBBIE WARPULA (577), JENNIFER KOSS (616)
Inspection No. / No de l'inspection :	2015_380593_0012
Log No. / Registre no:	S-000730-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 23, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	ROSEVIEW MANOR 99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE LENT

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (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 is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. Identification of the responsive behavioral triggers for resident #022, how these triggers will be managed and the interventions to be taken by each staff discipline when triggers are present.

2. Strategies to be used to engage resident #022 regularly in a variety of scheduled and non-scheduled activities ensuring regular mental and physical stimulation to prevent boredom and possible trigger of behaviours.

3. Details of the steps taken to minimize specific responsive behaviours displayed by resident #022 considering psychological, pharmaceutical, behavioural and physical interventions and steps to prevent resident #022 from being alone with specific residents or in any situation where resident #022 could exhibit specific responsive behaviours towards another resident.

4. Strategies taken to ensure that all staff report allegations of abuse immediately to the licensee.

Furthermore, the licensee is hereby ordered to comply with Policy #LP-C-20-ON: Resident Non-Abuse Ontario (dated September 2014).

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be faxed to the inspector's attention at the Sudbury Service Area Office. This plan must be received by August 7, 2015 and fully implemented by August 21, 2015.

Grounds / Motifs :

1. The licensee has failed to protect residents from verbal abuse by S#115.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to an incident of reported verbal abuse by S#115 toward resident #021. It was reported by S#116 that the resident requested assistance, S#115 then approached the resident and was verbally abusive toward the resident while providing assistance.

Under O.Reg. 79/10, verbal abuse is defined as “any form of verbal

communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

During an interview with Inspector #593 May 12, 2015, S#117 advised that they witnessed the incident of verbal abuse toward resident #021 by S#115. They reported that S#115 was very rude to the resident, rushing them and being verbally abusive toward the resident as S#115 was providing assistance to the resident. S#117 reported that there was a prior incident where S#115 was not pleasant toward a resident however they can no longer remember the exact details.

During an interview with Inspector #593 May 14, 2015, S#116 reported that they witnessed the incident of verbal abuse toward resident #021 by S#115. They reported that S#115 yelled to the resident and was verbally abusive toward the resident. S#116 reported this immediately and S#115 was taken off the floor. S#116 further advised that this incident was not isolated, and that S#115 had done this before and generally their behaviour was not acceptable towards residents.

S#116 advised that the incident happened on a Tuesday and S#115 was sent home pending the investigation the same day, however S#115 returned the following weekend as they were short staffed and S#115 worked both the Saturday and Sunday evening shifts.

During an interview with inspector #593 on May 14, 2015, S#118 reported that prior to the incident with resident #021, they witnessed the same resident standing in their doorway waiting for assistance from staff. S#118 saw S#115 yell very rudely at the resident when the resident requested assistance from the staff member. S#118 thought it was inappropriate but did not report it further. They also added that there was another incident where S#115 had said something to a resident, they cannot remember exactly what was said but made them think that it could have been considered abuse. At the time, S#118 said to S#115 that they should really be careful with what they say to residents in the home.

A review of the home's policy LP-C-20-ON Resident Non-Abuse-Ontario dated September 2014 found that any staff member or person, who becomes aware of

and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information upon which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the homes reporting requirements to ensure that the information is provided to the ED immediately. The home failed to ensure that their policy to promote the prevention of abuse and neglect is complied with as S#118 did not report to the ED or the most senior supervisor on shift at that time, the abuse toward a resident that they witnessed.

As witnessed by multiple staff members within the home, S#115 was verbally abusive towards residents on numerous occasions. It was reported by several staff members that prior incidents had occurred. As such, the licensee has failed to protect residents from abuse by a staff member in the home. [s. 19. (1)] (593)

2. The licensee has failed to protect residents from sexual abuse by resident #022.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #022 towards resident #017. The incident was reported by resident #017 and it was reported that this was non-consensual.

A CI was submitted to the MOHLTC in relation to a second incident of reported abuse by resident #022 toward resident #018. It was reported by a staff member that they found resident #022 in resident #018's room when the incident occurred and resident #018 was not cognitively aware however this incident was considered non-consensual.

A CI was submitted to the MOHLTC in relation to two incidents of reported abuse by resident #022 toward residents #019 and #023. It was reported by staff that resident #022 was found in resident #023's room at the time of the incident. Later that same night, staff reported that resident #022 was found in resident #019's room.

During an interview with Inspector #593 May 13, 2015, S#114 reported that two of the incidents of abuse towards residents #017 and #018 by resident #022 were reported to them after they occurred. They further advised that after these two incidents, increased staffing for resident #022 was initiated, however there

continued to be further incidents of abuse by resident #022 toward other residents in the home including residents #019 and #023.

During an interview with Inspector #593 May 15, 2015, the DOC advised that resident #022's behaviours have been difficult to manage and that is why they initiated increased staffing for this resident. The DOC further added that they really had to speak to PSWs about their role when providing additional care for resident #022, as initially when they were with resident #022, they would leave resident #022 to help their co-workers.

A review of the guidelines for staff when providing additional care to resident #022 found a list of strategies for monitoring this resident and preventing further occurrence of abuse.

A review of resident #022's health care record found documentation related to dementia observation system (DOS) charting commencing the date of the first incident of reported abuse towards a resident in the home. The DOS charting continued daily for approximately two months and during this period five additional incidents of abuse occurred by resident #022 toward multiple residents in the home. Numerous gaps were found in the DOS documentation during this period. During an interview with Inspector #593 May 15, 2015, the DOC advised that the DOS charting was being completed 24/7 and that any gaps would be related to non-charting.

A review of resident #022's health care record found a referral for a behavioural specialist dated several days before the first incident occurred. After the assessment was completed by the behavioural specialist, the assessment indicated the following: Writer reviewed the documentation and noted that there was documentation of the resident displaying responsive behaviours toward staff in the home for approximately the next six months.

Shortly after resident #022 was referred to the behavioural specialist, the specific responsive behaviours were witnessed toward residents in the home with multiple incidents of abuse being reported. A review of resident #022's progress notes showed a timeline of incidents of abuse and specific responsive behaviours towards residents in the home:

Progress Note 1
RPN at 2000h reported that resident #022 abused resident #023 while in a

conmmon area at 1950h as per residents report. Resident also stated that they pushed the resident away. ADOC informed at 2025h and would like staff to monitor the resident regularly.

Progress Note 2
RN informed writer at 1920h that a resident informed them that a resident abused them. Increased staffing at present for the resident.

Progress Note 3
It was brought to this RN's attention by a PSW that resident #022 apparently entered resident #017's room either last evening or during the night shift and was reported to have abused resident #017. Resident #017 had apparently screamed at resident and told them to leave the room.

Progress Note 4
PSW reported that resident #022 found in resident #018's room. PSW reported that resident #022 was abusing resident #018. RN aware of resident behaviour, more frequent checks during the night. ADOC was informed at 0745h and has requested additional monitoring of the resident.

Progress Note 5
Staff knew resident #022 was in the dining room when they started to do personal care on several other residents. Once finished, resident #022 was no longer in the dining room. Staff started to search unit and found resident #022 in another residents room.

Progress Note 6
Multiple incidents occurred overnight. Additional staffing in place immediately as soon as the writer made aware of incidents by PSW. Additional staffing in place for resident until further notice as per ADOC. Night PSW found resident #022 trying to move resident #023's bedside table, and displaying specific responsive behaviours towards the resident. The night PSW also reported that resident #022 was displaying specific responsive behaviours towards another resident.

The CI that was submitted for the sexual abuse incident toward female resident #017, documented that resident #017 was visibly upset by the incident and as a result, several interventions were put in place to help the resident feel safe. This was confirmed during an interview with the Administrator May 12, 2015, who reported that resident #017 was concerned and affected by the incident and as a

result of the incident, located to another room within the home on a different level to resident #022. Observations during the RQI, found that the resident still has the interventions in place to help them feel safe.

A review of resident #017's care plan, found a safety related focus and interventions relating to this.

Furthermore, it was found that the first two incidents of abuse towards two residents in the home were not reported to the Director of the Ministry of Health and Long-Term Care as per the 2007 LTCHA which states that abuse of a resident by anyone that resulted in harm or a risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

As evidenced by documented progress notes and staff interviews, resident #022 was known to display abusive behaviours towards residents in the home. Furthermore, after the first incident occurred with resident #023; five additional incidents of abuse were allowed to occur toward numerous residents in the home including at times when it was reported that the resident had interventions in place to monitor the resident. As reported, this has resulted in a resident requiring significant interventions to feel safe. The licensee has failed to protect residents within the home from resident #022 with known and documented inappropriate behaviours. [s. 19. (1)]
(593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The home must ensure there is:

(A) An organized and implemented program of nutrition care and dietary services for the home to meet the daily nutrition care needs of the residents.

(B) An organized and implemented program of hydration for the home to meet the hydration needs of residents.

This program must be fully implemented by August 21, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident is offered a minimum of, a between meal beverage in the morning and afternoon.

On May 8, 2015, Inspector #593 observed that no nourishment pass was undertaken in one of the units of the home. Inspector #593 observed between 1030 hrs and 1130 hrs in this area and observed that none of the residents in this unit were offered or provided a beverage during this time. A cart was observed in the kitchenette during this time which contained a variety of beverages. This cart was not touched by a staff member during these observations. Inspector #593 observed the posted time for the AM nourishment part in this unit was 1030 hrs. At 1130 hrs, the Inspector observed staff starting to set the dining room up for lunch including bringing residents into the dining room to be seated.

On May 11, 2015, at 1410 hrs, Inspector #593 observed S#101 provide beverages to three of the four residents in the common area of one of the home's units. The inspector observed this area from 1400 hrs until 1500 hrs and observed no other residents in this unit offered a beverage. The inspector observed 15 residents in this unit who were not provided or offered a beverage during this time. The posted PM nourishment time in this unit was 1400 hrs. A cart was observed in the kitchenette during this time which contained a variety of beverages. At 1500 hrs shift changeover was underway.

On May 13, 2015, at 1040 hrs, Inspector #593 observed two residents seated in the common area of one of the home's units who were provided a beverage. There were five other residents in this area who were not offered or provided a beverage at this time. Inspector #593 observed this area from 1025 hrs until 1130 hrs and observed that no other resident in the unit was provided or offered a beverage. The posted time in this unit for the AM nourishment pass was observed to be 1030 hrs. There were at least 21 residents in this unit during this time period that were not offered an AM beverage. A cart was observed in the kitchenette during this time which contained a variety of beverages. During the period of observation, the beverage care was accessed only once by a staff member who poured themself a juice however provided no beverages to any residents.

During an interview with Inspector #593 on May 14, 2015, the Nutrition Manager S#122 reported that the homes expectation for the AM and PM nourishment pass is that the dietary staff are to set up the carts with beverages and/or snacks and leave them in the kitchenette or dining room of each unit in time for the nourishment pass. The expectation is that the PSW who has been assigned that role that day will take the cart and offer/provide nourishment to the residents. They did further report that they have had issues in the past with the provision of between meal nourishments.

During an interview with Inspector #593 on May 14, 2015, the DOC confirmed that a PSW is assigned the nourishment pass in each of the home's unit. It is their responsibility to ensure that this is completed. The DOC further reported that they have had a lot of trouble with the nourishment pass being completed.

A review of the home's Policy: LTC-G-130 Between Meal Nourishments, dated December 2014, found that Between meal nourishments will be provided to

residents according to provincial regulations and residents' quality of life will be enhanced and nutrient requirements met through the provision of between meal nourishments. [s. 71. (3) (b)] (593)

2. The licensee has failed to ensure that each resident is offered a minimum of, a snack in the afternoon.

Inspector #593 on May 11, 2015, observed at 1410 hrs S#101 provide three of the four residents in the common area of one of the home's units a beverage. These residents were not provided or offered a snack. The inspector observed this area from 1400 hrs until 1500 hrs and observed no other residents in this unit offered a snack. The inspector observed 15 residents in this unit who were not provided or offered a snack during this time. The posted PM nourishment time in this unit is 1400 hrs. A cart was observed in the kitchenette during this time which contained only a variety of beverages. At 1500 hrs shift changeover was underway.

During an interview with Inspector #593 on May 14, 2015, the Nutrition Manager S#122 reported that the homes expectation for the AM and PM nourishment pass is that the dietary staff are to set up the carts with beverages and/or snacks and leave them in the kitchenette or dining room of each unit in time for the nourishment pass. The expectation is that the PSW who has been assigned that role that day will take the cart and offer/provide nourishment to the residents. They did further report that they have had issues in the past with the provision of between meal nourishments.

During an interview with Inspector #593 on May 14, 2015, the DOC confirmed that a PSW is assigned the nourishment pass in each of the home's unit. It is their responsibility to ensure that this is completed. The DOC further reported that they have had a lot of trouble with the nourishment pass being completed and that is why they started to assign a PSW to the task, to put the responsibility on them.

A review of the home's Policy: LTC-G-130 Between Meal Nourishments, dated December 2014, found that Between meal nourishments will be provided to residents according to provincial regulations and residents' quality of life will be enhanced and nutrient requirements met through the provision of between meal nourishments.

As a result of reviewing the severity and scope of the incident and the licensees' compliance history, the inspector identified that a compliance order was warranted. The severity of the incident was identified as minimal harm or potential for harm, the scope level was identified as pattern as multiple residents on two home areas were observed not to have been offered a between meal or evening beverage and / or a snack in the evening. The compliance history indicated that the licensee has had previous related non-compliance. O. Reg. 709/10. s. 71 (3). [s. 71. (3) (c)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 23rd day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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