Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 8, 2017	2017_548592_0005	027948-16, 002362-17, 002979-17	Complaint

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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

MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 02, 06, 07, 08, 09 and 10, 2017

The following complaints were inspected concurrently during this inspection:

Log #027948-16 related to an alleged staff to resident physical abuse incident
Log #002979-17 related to Residents' Bill of Rights
Log #002466-17 complaint and Critical Incident log # 002362-17 related to an alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the General Manager, the Director of Care (DOC), the Human Resource Coordinator, the Food Service Supervisor, the Support Outreach Nurse, Dietary Aids, , Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members and Residents.

During the course of the inspection, the inspector conducted a tour of the resident care areas, reviewed residents' health care records, Licensee policies and procedures, staff work routines, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On February 06, 2017, Inspector #592 conducted an observation of the dining room on the lower level of the home that serves as the main dining room for the home. As such, residents eat their meals at a first or second meal seating and access the dining room by the elevator.

The Inspector was unable to locate a resident-staff communication and response system in the dining room.

The Administrator indicated to Inspector #592 that there was no call bell in the dining room. She further indicated that staff would use the phone located in the back corner of the kitchen as a pager if assistance in the dining room was required.

The Inspector observed that the phone was not seen and not accessible for residents and visitors from the kitchen area which is a non-resident area and that their was no indication when the pager system is activated where the signal was coming from.

A Voluntary Plan of Correction was issued in March 2015, inspection # 2015_225126_0012 and December 2016, inspection # 2016_219211_0023 following the RQI inspections.

Following the issuing of these Voluntary Plans of Corrections, there was no observed corrective actions taken by the licensee. [s. 17. (1) (e)]

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 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 has failed to ensure that that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

Two complaints and a critical incident were submitted to the Ministry of Health and Long Term Care regarding residents being left alone on the unit with one PSW covering for the three floors during mealtime services. (Log #002362-17, 002466-17 and 027948-16 related to resident #001)

Sarsfield Colonial home is a 46 bed Long-Term Care Home in Sarsfield. The home has a total of four levels. 15 residents are residing on the first floor, 15 on the second floor and 16 on the third floor. The dining room is located on the ground level which is accessible by one elevator. The organized program of personal support services is two PSW's for each floor on day shift, five PSW's on evenings (two on the first and third floor and one on the second floor) and two PSW's on night shift with one registered nurse covering the building.

Inspector #592 did a review of resident #001 health care records.
The resident's health care records indicated that on a specified date in January 2017, at a specified time, resident #001 was found by a family member with swelling and bruising to a specified body part. The resident's health care records further indicated that upon their arrival to the home, resident #001's family members were told by resident #001, that he/she was punched by resident #002, following a dispute. The resident's health care records further indicated that the family members informed RN #102 of the incident.

On February 02, 2017, during an interview with the family member of resident #001, he/she indicated to the inspector that on the day of the incident, when he/she came to visit the resident with three other family members, they found the resident in the corridor with swelling and bruising on a specified body part. The family member indicated to the

Inspector that there was no staff around and therefore the family stayed with the resident and the other family members went out on other floors to try to get assistance from a staff member. The family member indicated that approximately 20 minutes went by before one of the family members found the Charge RN who was located on the second floor nurses station.

On February 07, 2017, at 1225 hours, while doing a tour on a specific floor, Inspector #592 observed a total of six residents in their room. No staff members were observed on the floor. When Inspector #592 entered one specific room, resident #006 was observed sitting in his/her wheelchair, rubbing his/her abdomen and told the Inspector that he/she needed to go to the washroom. Inspector #592 noted that there was no calling bell accessible for the resident and when ask resident #006 where the calling bell was, the resident told the Inspector that he/she was not able to locate it.

At 1228 hours, Inspector #592 observed PSW #107 exiting the elevator on a specific floor. PSW was informed by the Inspector that resident #006 needed assistance. When Inspector inquired about the accessibility of the call bell, PSW #107 was unable to locate the call bell. PSW #107 was observed, moving the bed frame and the side rails to try to grab the calling bell cord which was stuck between the wall and the bedframe. Resident #006 told PSW #107 that he/she felt the urge to go to the bathroom and that he/she was in pain while rubbing his/her abdomen. PSW #107 indicated to the resident and the Inspector that she would have to reach a co-worker by using the phone on the floor in order to provide assistance to the resident who was assessed as a two person transfer for toileting.

At 1243 hours, 15 minutes after the resident requested to be toileted, a co-worker arrived to provide assistance to PSW #107 to toilet resident #006.

On February 08, 2017, at 1215 hours, Inspector #592 arrived on a specific floor and noticed that the calling bell in a specific room was activated. Inspector #592 did a round on the unit and was not able to locate any staff members. Inspector #592 entered the room and resident #006 and a family member were present. The family member indicated to the Inspector that the resident needed to use the washroom, therefore the family member has rang the calling bell several minutes ago to receive assistance. The family member further indicated to the Inspector that they have to wait until a PSW is available on the floor as PSW were busy with the meal service and that this was an ongoing issue if resident #006 requires to use the washroom at lunchtime. The family member also indicated to the Inspector that the resident has to wait until the meal service

is completed as there were no staff available to provide assistance.

At 1220 hours, PSW #107 was observed by the Inspector, exiting from the elevator and assisting a resident in a wheelchair back to his/her room and then return to the elevator. When Inspector #592 inquired about the ringing call bell, the PSW then proceeded to resident #006's room and was informed by the resident and the family member that the resident needed to use the washroom. PSW #107 told resident #006 and the family member that she could not assist the resident at this time as she was assisting to bring residents back to their room from the dining room downstairs. PSW #107 further indicated to the resident and the family member that she was alone at that time but that she would ask for assistance whenever she could find someone.

At 1226 hours, 11 minutes later, PSW #107 had returned to the floor with another co-worker to assist resident #006.

On February 07, 2017, during an interview with PSW #110, it was indicated to the Inspector that there was two separate seatings at meal times. She further indicated to the Inspector that in order to ensure the resident's safety after they return to the floor from the first meal service, a PSW was assigned to stay on the second floor during the second seating meal service on days and evening.

PSW #110 further indicated that visual checks were done every 15 minutes on the first and third floor. The 15 minutes checks consisted of checking for any activated call bells by residents who needed assistance and then PSW goes back on the other floors after the check. The PSW further indicated that there was no need to go in each resident's room and that there was no specific form to be used other than following the routine of the 15 minutes check.

On February 07, 2017, during an interview with the DOC, she indicated that the home has two seating at each meal service. She further indicated that there was one PSW assigned to the second floor, once all residents are back from the first seating and that a visual check was performed every 15 minutes on each resident's room on the first and the third floor. The DOC further indicated that once the visual check was done, PSW were to document the date, time and their initials to ensure that the visual check was completed on the 15 minutes eye check form. The DOC further indicated to the Inspector that the 15 minutes eye check form and a checklist of the residents who were given the authorization to stay on the floor without supervision were located in the PSW binders on each floor.

The DOC further indicated to Inspector #592 that each resident was assessed upon admission and whenever there was a significant change in condition thereafter, for authorization to stay on the floor without supervision. The DOC or a Registered Staff used the form titled "safety assessment for ability to stay in room without supervision" to assess the residents. In addition, the DOC indicated that the home uses calling bells as their resident-staff communication system. When a resident activates his/her call bell when requiring assistance, there is an alarm that can be heard throughout the hallway on each floor. Only the staffs present on that particular unit can hear the alarm therefore during meal times, if a resident on either the first or the third floor activates his/her call bell when in need of assistance or an emergency, the call would only be audible to the staff during the 15 minutes interval visual checks.
It is to be noted that the home's call bell system is not connected to pagers for the direct care staff to be notified if a resident rings for assistance in between the 15 minutes visual checks.

The DOC provided a list of the residents who were allowed to stay in their room without staff supervision on the floor to Inspector #592. The list indicated that there was a total of eight residents on the first floor and two residents on the third floor who were not requiring supervision.

A review of the list of residents who were allowed to stay in their room without staff supervision was done by Inspector #592.
The list indicated that resident #013, #001, #014, #011, #002, #012, #015, #016, #017 and #018.

Inspector #592 noted that resident #006 and #007 located in a specific room, were observed with no supervision at lunch time on February 07 and 08, 2017, and were not on the list provided by the DOC. Furthermore, Inspector #592 observed resident #008 and #009 located in another specific room, who were also observed with no supervision at lunch time on February 07 and 08, 2017 and were not on the list provided by the DOC.

A review of the "safety assessment for ability to stay in room without supervision" form was done by Inspector #592.
The following residents identified on the list were reviewed.

Resident #001, was assessed on a specific day in May 2016 and was identified at risk to

be unsupervised, but the form indicated that resident has consented to stay in the room with no supervision.
Resident #002, was assessed on a specific day in June 2016 and was identified at risk to be unsupervised, but was identified to stay in the room with no supervision.
Resident #010, was assessed on a specific day in September 2015 and was identified at risk to be unsupervised and not allowed to stay in the room with no supervision but was on the resident list who were allowed to stay in their room and was observed by Inspector #592 on February 07 and 08, 2017, to be on the unit unsupervised.
Resident #011, No assessment was found
Resident # 012, No assessment was found

Upon a review of the 15 minutes eye check form for January 2017, it was noted that of the 31 days, there was no visual eye check recorded for 24 days. Upon a review of the 15 minutes eye check from for February 01 to February 07, 2017, there was no documentation recorded.

On February 09, 2017, in an interview with the DOC, she indicated to the Inspector that the residents who were not identified on the list, were resident who were done with their meals earlier and were brought back on the floor until the meal was completed. The DOC further indicated that residents are not always re-assessed when there is a change in their condition and the forms not always completed and that registered staff will use their judgement in deciding if the resident can stay unsupervised in his /her room. [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 the residents needs will be met during meal services, to be implemented voluntarily.

WN #3: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).

This inspection was conducted following a complaint of a staff to resident alleged physical abuse which occurred during a specific date in September 2016. The complaint

further indicated that the incident involved resident #001 who was held down by one staff member while another staff member punched him/her. The complaint further indicated that this may not fully be true as resident is in the earlier stages of dementia, but that this could have been the staff forcing the resident to take his/her medications.

A review of the resident #001's health care records indicated that the resident is identified with several medical diagnosis and that he/she is his/her own Power of attorney. In addition, the resident's #001's health care records was reviewed for September 2016 and no documentation was found regarding the incident of alleged physical abuse.

On February 09, 2017, during an interview with resident #001, he/she indicated to Inspector #592 that he/she recalls several months ago that he/she has refused to go to bed and that a nurse and a PSW were in his/her room trying to convince him/her to go to bed. The resident further indicated to the Inspector that both staff members were trying to have him/her in bed but he/she refused again. The resident further told Inspector that he/she was punched by the PSW, and did a description of both staff members involved in the incident. The resident further described the incident as being held by the nurse in order to be punched by the PSW. He/she further indicated that he/she has contacted the police the following day and that everyone in the home were informed but does not recall the names of the staff members who responded to the incident.

Inspector #592 reviewed the licensee's " Zero Tolerance to Abuse and Neglect" Policy, effective date of September 24, 2014 which indicated the following under Preliminary Written Report/Inquiry:

A. Regardless of the action taken, the supervisor to whom the incident had be reported will conduct an inquiry and complete a preliminary report before going off duty.
C. The preliminary written report shall contain the following:
a) Date, time of incident (when)
b) what happened
c) who were involved (including witnesses)
d) where dit it happen
e) why did it happen and was there anything that could have been done to prevent it
f) written statements from all witnesses (if resident unable-supervisor will write)
g) any other significant
h) information having a bearing on the incident

On February 10, 2017, during an interview with the DOC, she indicated to the Inspector that all events related to a reported allegation of abuse should be investigated and documented by using a specific form. She further indicated that she recalls vaguely about being reported about the incident of alleged physical abuse involving resident #001 and two staff members. The DOC further indicated that she does not remember who reported the incident but that the following day when she became aware of the incident, she conducted an investigation and interviewed staff members involved in the incident, including resident #001. She further indicated to the inspector that she was not able to find the written report but that following the home’s internal investigation there was no reasonable grounds to suspect that alleged abuse had occurred to resident #001.

On February 10, 2017, during an interview with the General Manager, he indicated to the inspector that he was made aware by staff members about an incident of alleged physical abuse involving resident #001 and a staff member. He further indicated that he conducted an investigation and that there was no reasonable grounds to suspect that alleged abuse had occurred. The General Manager further indicated that he did not completed any written report as per the home’s policy. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains explanation of the duty under section 24 of the Act to make mandatory reports.

The Administrator provided the licensee's policy to promote zero tolerance of abuse and neglect of residents, upon the request of Inspector #592.

A review of the policy indicates elements of reporting to the Ministry of Health and Long Term Care (MOHTLC)(i.e Director). However, explanations related to the reporting of abuse and neglect of residents, do not indicate immediate reporting. The explanations provided does not clearly indicate that a person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall be reported immediately. In addition, reporting requirements are described based on the results of the home's investigation, whereby when an investigation indicates that a resident has likely suffered abuse the Manager or designate will decide to report to the MOHLTC .

On February 06, 2017, in an interview with the DOC, she indicated to the Inspector that she was notifying the Director by using the Critical Incident Form, but was not aware of the after hour contact line to immediately notify the Director.

On February 07, 2017, in a review of the licensee's policy with the Administrator, she indicated that the home was aware to report immediately to the Director. She further indicated that she was not aware of the after hour contact line to immediately notify the Director nor was she aware that the licensee's policy to promote zero tolerance of abuse and neglect of residents was not indicating the immediate reporting requirements. [s. 20. (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 the home will comply with their policy to promote zero tolerance of abuse and neglect and that the policy will contain explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #4: 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 a person who has reasonable grounds to

suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

According to O.Reg.79/10, s.2.(1) physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

Related to Log# 002362-17 and Log # 002433-17

Inspector #592 completed a review of resident #001 health care records. The resident's health records indicates that on a specified date in January 2017, at a specified time, resident #001 was found by his/her family member with swelling and bruising on a specified body part. The resident health care records further indicated that resident #001 had inform his/her family members that he/she was punched by resident #002, following a dispute. The resident health records further indicated that the family members informed RN #102 of the incident.

On February 02, 2017, during an interview with resident #001, he/she indicated to the inspector that he/she was punched about two weeks ago by resident #002 following a dispute. Resident #001 further indicated that during the verbal dispute, resident #002 punched him/her and that he/she experienced pain. The resident further indicated that he/she inform his/her family but not the nurse as he/she thought that she probably was already aware.

On February 02, 2017, during an interview with RN #102, she indicated to the Inspector that she observed resident #001 while administrating his/her medication at a specific time and that a redness was present to a specific body part but that when she asked the resident what happened, the resident told her that nothing happened. RN #102 further indicated that at approximately 60 minutes after, one of the resident family member came while she was having her dinner to get her and was inquiring on what happened to resident #001. RN #102 indicated that she was at the same time informed by the resident and the family member about resident #001 being punched by resident #002. She further indicated to the Inspector that upon being made aware she did an assessment of resident #001 injury and noticed that it had gotten worse since she first saw the resident 60 minutes ago and has contacted the physician. She further indicated to the Inspector that resident #002 reported that he/she punched resident #001 during a dispute. RN #102 indicated to the Inspector that the Police and the Home's General Manager were contacted and that the Home's General Manager took over.

On February 02, 2017, during an interview with the General Manager, he indicated to the Inspector that he was contacted on the day of the incident and that he came immediately on site. He further indicated that the home's process upon becoming aware of an incident of alleged abuse is to inform the Director by sending a critical incident which is done by him or the DOC. The General Manager further indicated that he did not call the Director immediately upon becoming aware of the incident on that evening because he thought that it could of wait until the next day. He further indicated to the Inspector that the DOC was not working on the next day. Therefore, the information pertaining to an alleged physical abuse was not reported immediately.

A VPC was issued in June 2016, inspection #2016_290551_0013 following an RQI inspection. [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 abuse of a resident by anyone has occurred or may occur, immediately report to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

On February 08, 2017, PSW #111 was observed by Inspector #592 in the lounge room located on the first floor during the breakfast meal service, feeding resident #004, #005 and #006. PSW #111 was observed by Inspector #592 to be standing at the side of the resident's wheelchair while feeding them.

On February 08, 2017, during an interview with PSW #111, she indicated to the Inspector that she should be sitting while providing assistance to the residents but because there was no available furniture when staff are providing breakfast in the lounge area, she was unable to sit while assisting the residents to eat.

A review of resident #004, #005 and #006 plan of care was done by Inspector #592.

The current plan of care for resident #004, indicated that the resident sometimes needs extensive assistance as he/she was sometimes unable to feed himself/herself.
The current plan of care for resident #005, indicated that the resident was to be provide with total feeding assistance as he/she was unable to feed himself/herself.
The current plan of care for resident #006, indicated to always sit facing the resident when feeding him/her and to provide supervision for all meals and snacks.

On February 09, 2017, during an interview with the Food Service Supervisor (FSS), she indicated to the inspector that the nursing staff were aware that they were not supposed to feed residents while standing as part of the pleasurable dining experience. She further indicated that she will ensure that proper techniques to assist resident with eating will be put in place, as well as furniture available for staff members. [s. 73. (1) 10.]

2. The licensee has failed to ensure that the home has a dining and snack service that included appropriate furnishings and equipment in resident dining areas.

Related to log #027948-17.

On February 07, 2017, Dietary Aide #106 provided Inspector #592 with the weekly menu cycle in place and used by the home.
Upon a review of the menu, Inspector #592 noted that on Wednesday's, Thursday's and Sunday's the menu was indicating that "Baked Goods" was to be sent up around 8AM on each floor.

On February 07, 2017, during an interview with Dietary Aid #106, she indicated to the Inspector that on the Wednesday's, Thursday's and Sunday's, the residents breakfast was served in the a lounge room, located on each floor. She further indicated to Inspector #592 that she prepares a cart for each floor, which she brings upstairs to each floor for the breakfast meal service.

On Wednesday February 08, 2017 at approximately 0800 hours, Inspector #592 observed on the first floor a room titled "lounge" with five residents sitting at one table and three residents sitting at the back of the room in their wheelchair with no table top. PSW #111 was observed standing and providing assistance to the three residents in their wheelchairs at the back of the room. PSW #111 was holding the residents breakfast meal plate as there was no dinning table. No chairs were observed by Inspector #592 for the staff members to use while feeding the residents.

On Wednesday February 08, 2017 at approximately 0815 hours, Inspector #592 observed on the third floor, a room titled "lounge" with seven residents sitting in their wheelchairs along the wall. There was two tables available located at the back of the room which was being used by two residents.

On February 09, 2017, while conducting a tour of the lounge room with the presence of

the Food Service Supervisor (FSS), she indicated to the inspector that due to the time spent when using the elevator as there was only one elevator available to bring the residents up and down for meals, that the lounge on each floor were used three times a week for the convenience of staff and residents. The FSS further indicated that there was no seating plan on these lounges and that the residents who were identified with no table top on there wheelchairs were usually using one but the table tops were probably left in their rooms. She further indicated that some of the residents observed were usually requiring limited assistance but due to the non-furnishing and equipment available, staff member were to assist them by holding their plates and feeding them. [s. 73. (1) 11.]

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 proper technique are used to assist resident with eating, as well as having appropriate furnishings and equipment in residents dining areas, to be implemented voluntarily.

Issued on this 9th day of March, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2017_548592_0005
Log No. / Registre no:	027948-16, 002362-17, 002979-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 8, 2017
Licensee / Titulaire de permis :	TAMINAGI INC. 05 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1
LTC Home / Foyer de SLD :	SARSFIELD COLONIAL HOME 2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHANTAL CRISPIN

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1. Ensure that the main dining room is equipped with a resident-staff communication and response system which meets all of the requirements listed above, and;
2. Take immediate action to mitigate risks associated with this situation until this non-compliance has been rectified by the Licensee and found to be in compliance by a LTCH Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On February 06, 2017, Inspector #592 conducted an observation of the dining room on the lower level of the home that serves as the main dining room for the home. As such, residents eat their meals at a first or second meal seating and access the dining room by the elevator.

The Inspector was unable to locate a resident-staff communication and response system in the dining room.

The Administrator indicated to Inspector #592 that there was no call bell in the dining room. She further indicated that staff would use the phone located in the back corner of the kitchen as a pager if assistance in the dining room was required.

The Inspector observed that the phone was not seen and not accessible for residents and visitors from the kitchen area which is a non-resident area and that their was no indication when the pager system is activated where the signal was coming from.

A Voluntary Plan of Correction was issued in March 2015, inspection # 2015_225126_0012 and December 2016, inspection # 2016_219211_0023 following the RQI inspections.

Following the issuing of these Voluntary Plans of Corrections, there was no observed corrective actions taken by the licensee. (592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 12, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 8th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

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