Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2018	2018_606563_0012	012821-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Seaforth Long Term Care Home
100 James Street SEAFORTH ON N0K 1W0

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

MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 9, 10, 11, 12, 13, 16, 17, 18, 19 and 20, 2018

The following intakes were completed as part of the Resident Quality Inspection (RQI):
018774-17 - 1135-000008-17 - Critical Incident related to a missing resident
022134-17 - 1135-000010-17 - Critical Incident related to resident to resident abuse
021094-16 - 1135-000009-16 - Critical Incident related to suspected staff to resident abuse

005023-16 - 1135-000004-16 - Critical Incident related to suspected staff to resident abuse
000341-18 - 1135-000002-18 - Critical Incident related to a fall
005550-18 - 1135-000005-18 - Critical Incident related to a fall
017906-18 - 1135-000012-18 - Critical Incident related to suspected staff to resident abuse
018078-18 - 1135-000013-18 - Critical Incident related to suspected staff to resident neglect

The following intakes were completed as an onsite inquiry during the RQI:
006451-18 - 1135-000004-18 - Critical Incident related to suspected staff to resident abuse
008003-18 - 1135-000006-18 - Critical Incident related to a fall
016701-18 - 1135-000007-18 - Critical Incident related to a missing resident

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, the Assistant Director of Care, the Program Service Manager, the Restorative Care Coordinator, the Quality Manager, the Wound Care Coordinator/Resident Assessment Instrument Coordinator, Maintenance Staff, Registered Nurses, Registered Practical Nurses, Residents' Council President, Family Council Representative, residents and family members.

The inspector(s) also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed various meeting minutes and written records of program evaluations and education.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained in a good state of repair.

During the initial Resident Quality Inspection (RQI) tour, damaged floor tiles, baseboard tiles, corner protectors and chipped paint on door frames in common areas of the home were observed.

During a follow-up observation the following was identified:
- Stained damaged floor tiles in the dining room;
- Damaged baseboard tiles along the walls in the hallways near the following areas: the elevator, the Wilson Street Entrance, the Chart Room, the Linen Room, and 10 out of 27 resident rooms (37 per cent);
- Damaged floor tile in the hallway outside;
- Chipped damaged paint on door frames to Spa Room, Linen Room, and 18 out of 27 resident rooms (67 per cent).

The General Manager (GM) said that the home's preventative and remedial maintenance service program included replacing floor and wall tiles and painting. The GM said that these were checked on a regular basis and there had not been a lot done with repairing these areas as it had not been a main focus. The Inspector and the GM toured the hallways of the home together and the GM acknowledged that there were floor tiles, baseboard tiles and door frames that were in disrepair. The GM provided the "Floor Repair" documentation for 2018 and said that it showed there had been some floor tiles repaired in specific locations and only two areas where the tile baseboards had been repaired. The GM provided the "Painting Chart" for 2017 and 2018 and said that this showed that there had not been any door frames painted in the home during that time. The GM said that it was the expectation in the home that these areas would kept in good repair.

Based on these observations and interview the licensee has failed to ensure the floor tiles, baseboard tiles and door frames of the home were in good repair. [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 the home is maintained in a good state of repair, to be implemented voluntarily.

WN #2: 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 was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by the resident at all times.

During "stage 1" of the Resident Quality Inspection (RQI), the call bell was observed at the bedside for a resident, and when pressed, did not provide an auditory signal in the hallway. On a different day, the Inspector observed that the call bell at the bedside for the resident and when pressed, did not provide an auditory signal in the hallway. The

Inspector activated the call bell at the bedside and asked the Registered Practical Nurse (RPN) if they could hear the auditory signal in the hallway, and they said no. The RPN paused to listen for the auditory signal and then stated yes, they could hear the auditory signal from the nursing station, but it was faint. When asked if the RPN was in a location away from the nursing station assisting another resident, how they would hear the alarm, the RPN stated that staff at the nursing station would communicate verbally that the alarm was triggered.

The Personal Support Worker (PSW) stated that they relied on the sound of the call response system to know if a call bell was activated. They stated that the call bell auditory signal for the resident’s room was faint, but louder on the panel at the nursing station. The PSW activated the call bell in the bathroom and it was more audible in the hallway. When asked, the PSW stated that the residents in this room use their call bells when in bed.

During "stage 1" of the RQI, the call bell at the bedside was observed for another resident. The call bell did not work when pressed, and the visual signal did not activate in the hallway outside the resident's door, or on the panel at the nursing station. The Inspector pressed the alarm which activated the signals on two out of 10 attempts (20 per cent). The Inspector spoke with a Health Care Aide (HCA) who verified that the bedside call bell did not activate each time it was pressed, and stated that the call bell was loose and the connection at the wall was to be tightened. The resident stated that they had concerns with their call bell a few days ago. The resident stated that when they pushed the call bell button at the bedside, it did not work.

During "stage 1" of the RQI, the call bell was observed at the bedside for a third resident, and when pressed, did not provide a visual or auditory signal. The resident stated that their call bell had not been working properly for a while. The resident was observed pressing the bedside call bell and it did not provide a visual or auditory signal. The resident stated that they had reported to staff that the call bell was not working. The Registered Nurse (RN) entered the room and attempted to activate the call bell and said it did not work. The RN pressed the call bell several times before the call bell was activated.

The Maintenance Staff stated that they check the call bell system for residents periodically throughout the week. They stated that if they were in a room providing maintenance, they would check to see if the call bell system was functioning. The Maintenance Staff stated that they had recently changed the call bell light in two of the

residents' rooms and stated that staff would report concerns with resident call bell systems on a report titled Faulty Call Bell Report.

Review of the home's call bell maintenance report titled Faulty Call Bell Report showed that a request stated that a resident's "call bell won't work!" with a maintenance check/fixed date. The report showed a request stated "unable to hear call bell clearly" for a resident's room.

The HCA stated that the resident call bells are checked every morning on their shift and was documented in tasks on Point of Care (POC). The HCA stated that they checked to see that the call bells turn on and function properly. When asked if the HCA had concerns with the functioning of the call bell system for any specific residents, the HCA pointed to the individual rooms of two residents, and stated that both rooms had issues with call bell functioning. The HCA said that one of the resident's call bell was loose a few months ago, and the home replaced it with a new call bell cord. The HCA said that the other resident's room had call bell functioning issues and the home had to order all new parts.

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by

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 is equipped with a resident-staff communication and response system that could be easily seen, accessed and used by the resident at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged incident of abuse of a resident that was reported to the licensee was immediately investigated and appropriate action was taken in response to every such incident.

Section 2(1) of the Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident."

Section 2(1) of the Ontario Regulation 79/10 defines emotional abuse "action or behaviour performed by anybody except by a resident including any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization."

During a "stage 1" interview for the Resident Quality Inspection (RQI) a resident was asked if they felt that the staff treated them with respect and dignity and the resident responded "no." When asked if staff had yelled or been rude to them the resident said "yes." The resident explained the incident to the Inspector.

During a follow-up "stage 1" RQI interview the resident told the Inspector specific details related to their concerns.

The resident's family member told the Inspector that the resident had also expressed

concerns to them about the care they were receiving on a specific shift. The family member said that the resident told them that prior to the "stage 1" interview with the Inspector. This family member said they had not spoken to management in the home about this yet.

The Director of Care (DOC) told the Inspector that the resident had spoken with the Restorative Care Coordinator (RCC) about their concerns related to care. The DOC had not spoken with the resident and stated that the RCC had spoken with the resident's family and in response the RCC left a note for the staff explaining the details of the incident. The Inspector then again described the "stage 1" questions that were asked and that the resident had expressed concerns that the staff were not providing care as preferred by the resident. The DOC said that they were not aware of the concerns, but that these were things that would not be acceptable. The DOC said that they were planning to follow-up with the staff.

The resident told the Inspector that the RCC and the DOC had both spoken with the resident regarding their concerns about the care on a specific shift. The resident said they felt they were not spoken to in a respectful way and said they had reported this to the RCC the day before.

The RCC said that the resident expressed specific concerns and the RCC said they left a note for the night staff about the concerns of the resident. The RCC said this note did not direct staff to change the care practices rather was asking for their input and the RCC said they no longer had a copy of the note they left. The RCC said that they spoke with the resident and their family member again about care concerns. The RCC said they spoke with the DOC about the concern and documented this in the progress notes.

The DOC told the Inspector that the RCC told them that the resident had specific care concerns. The DOC said that they were not sure about what was said by the resident to the RCC. The DOC said they had also spoken with the resident, but did not ask about the concerns related to one particular issue. The DOC said that as they were leaving the resident's room the resident said that the staff could be more empathetic. When asked if the DOC questioned the resident about what was meant by more empathetic, they said "no" as they felt the RCC had already talked to the resident. When asked if the RCC reported to them that the resident had said they felt staff did not speak in a pleasant way, the DOC said "no". The Inspector then told the DOC that the resident had expressed concerns during a follow-up interview regarding the way the staff were speaking with them as they felt it was not respectful. The DOC said that they would look into this issue,

identify which staff were working and speak with the resident.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) which was identified as an allegation of staff to resident abuse. This report indicated there had been an alleged abuse by staff to the resident and that the Inspector had reported this to the management. Under the question "What immediate actions have been taken to prevent recurrence?" the report stated staff will be notified of allegations and no other actions were documented.

The clinical record for the resident showed that the DOC documented a progress note in Point Click Care (PCC) which identified the allegation of abuse that had been reported to them by the Inspector. This note stated details of the reported concerns and that a CIS was initiated and full investigation commenced.

The DOC said that they had started the investigation into allegation of staff to resident abuse and submitted a CIS report to the MOHLTC based on what the Inspector had reported to them. When asked about the progress note that the DOC had documented, the DOC said that this was not the usual practice for documenting allegations in an abuse investigation and wanted to document it there so that the inspectors would know they were doing something about the allegations. The DOC acknowledged that the home's prevention of abuse and neglect policy indicated that confidentiality of all information related to the incident would be maintained in keeping with the Whistleblower Protection policy. When asked if they thought the progress note maintained the confidentiality of the concern the resident brought forward, the DOC acknowledged that it did not. When asked if staff had been interviewed, the DOC said "no." When asked if they knew of the details of the concerns the resident brought forward during the interview, the DOC said that they just knew that the resident was upset and did not want to get anyone in trouble. The DOC said that the process in the home for completing investigations into allegations of abuse would be to follow the "Zero Tolerance of Resident Abuse and Neglect Program" policies.

The home's "Zero Tolerance of Resident Abuse and Neglect Program: Investigation and Consequences RC-02-01-03" written policy which was last updated April 2017 included the following procedures:
- "All reported incidents of abuse and/or neglect will be objectively, thoroughly and promptly investigated
- "The Administrator or designate will oversee the completion of all steps required by the policy and procedures in order to manage the case to resolution. This includes: j.

Maintaining confidentiality regarding the report and all involved."
- "During the investigation the investigating manager/supervisor will a. Maintain the security and integrity of the physical evidence at the site of the incident, fully investigate the incident and complete documentation of all known details in keeping with the steps outlined in the investigation toolkit."

The home's "Whistleblower Protection RC-02-01-05" written policy which was last updated April 2017 included the following procedures:
- "Maintain the anonymity of any individual who makes a legitimate disclosure and/or testifies, where circumstances warrant. Through the course of an investigation, the Administrator/designate and all those involved through the course of the investigation will undertake all reasonable efforts to protect the confidentiality of the complainant."

The Registered Nurse (RN) told the Inspector that they had been involved in interviewing the resident, as the DOC had asked them to speak to the resident. The RN said that during the interview the resident told them that they had the concern for a while regarding the care they received on a specific shift. When asked what they did after the interview, the RN said that they had been asked by the DOC to call the staff to let them know there had been an allegation of abuse and it was their shift. The RN said they spoke with two Personal Support Workers (PSWs). The RN said they then spoke with the DOC regarding the details of the interview.

The Quality Manager (QM) told the Inspector that they had taken over the lead for the investigation for the CIS report. When asked how they had become involved in the investigation, the QM said they had been on vacation at the time of the allegation and when they returned was asked to investigate the alleged incident. The QM said that the DOC had started the investigation as fact gathering and had expressed that they felt they may have compromised the investigation and had wanted to step back and have someone look at it from a fresh perspective. The QM said that the usual process for an investigation was to interview all parties starting with the resident and any staff members and any witnesses and document. When asked what was done for the investigation before they were involved, the QM said that a CIS report was initiated and the Regional Director was notified. The QM said they did not know if the DOC had spoken with the resident as there was no documentation about this in the investigation file. The QM said there were documented notes that the RN and the RCC had spoken with the resident. When asked what was done after a specific date, the QM said that someone had directed staff regarding the resident's care, but they were not sure by whom or when that direction had been provided to staff. The QM said that nothing further was done for the

investigation until several days later and that was when they personally went to speak with the resident. The QM said that during that interview the resident said there was an ongoing concern related to a variety of care issues on a specific shift. The QM said they asked if there were any other concerns and the resident had said it was just how the staff were treating them and the resident responded that it was "better now." The QM said that the resident told them that they should have reported their concerns sooner. When asked what they did next for the investigation the QM said that they interviewed four PSWs and then interviewed the RCC and the RPN. The QM said that during the staff interviews no staff admitted to the incident and staff were not able to provide any information about this incident or about the concerns with how staff were treating the resident. The Inspector and the QM reviewed the staff interview documentation included with the home's investigation package and the QM acknowledged that the only questions and responses documented were related to the resident's personal care issues, and no questions regarding the investigation into allegations of emotional or verbal abuse. The Inspector and the QM reviewed the home's Zero Tolerance of Resident Abuse and Neglect policies together and the QM said it was the expectation in the home that investigation would be completed thoroughly and promptly. When asked what was meant by promptly the QM said that it meant right away. The QM said since the first documentation of this complaint, the investigation started two days later, with a resident interview and then the staff interviews conducted five days after that. The QM said that the interviews with staff were likely not completed in a quick time frame.

Based on interviews, policy review and record review the home did not immediately investigate the allegations of abuse reported by the resident to staff. The home failed to respond appropriately to allegations of staff to resident abuse as they did not comply with their written "Zero Tolerance of Resident Abuse and Neglect Program" policies, the management of the home notified staff of details of the allegations prior to staff interviews being conducted, the management did not keep the allegations made by the resident confidential and the home did not have documented evidence that the staff interviews had included questions specific to the allegations of verbal and emotional abuse. [s. 23. (1)]

2. The licensee has failed to ensure that every alleged incident of abuse of a resident that was reported to the licensee was immediately investigated and appropriate action was taken in response to every such incident.

Section 5 of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or

well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Section 2(1) of the Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident."

During a "stage 1" interview for the Resident Quality Inspection (RQI) the resident was asked if staff had yelled or been rude to them and the resident said "yes." The resident said that staff members yelled at the resident and did not assist them when the resident called out for assistance. Later that day the resident stopped the Inspector in the hall and asked to speak. The resident repeated again that the staff did not assist the resident when they called out after a suspected injury.

The Director of Care (DOC) and General Manager (GM) were informed that the resident had brought forward concerns during a "stage 1" interview. The DOC was not aware of an incident involving staff and the resident's complaints. The DOC stated that the resident had spoken to them previously, but that was in order to report a different allegation of abuse by a non-staff member. The DOC stated that they did not talk to the accused, and did not document the reported incident anywhere and there were no notes related to the concern brought forward by the resident previously.

A handwritten note by the DOC stated that the nursing staff were called and asked if there was any incident with the resident and two registered staff and three PSWs replied "no". No other questions were asked of the night staff at that time.

The DOC stated that they did follow up with the resident and their conversation was charted in the resident's progress notes in Point Click Care (PCC). The DOC verified that the resident repeated the same concern. The DOC also added that the progress note also documented the concerns related to the previously reported allegations of abuse. The DOC said an internal investigation had been started and had reached out to the staff and so far no one could recall an incident reported by the resident during "stage 1" of the RQI.

A progress note created by the DOC stated the details of the resident's conversation with the Inspector and their care concerns. The note documented that the resident reported specific details related to an incident. The progress note documented that an internal investigation would be started. The DOC also documented as part of this note that the

resident reported mistreatment by a non-staff member.

The DOC stated that the resident was interviewed and the resident reported the incident where the staff did not give the resident the care and services required after a possible injury. The DOC was asked was if there were reasonable grounds to suspect that the resident was neglected after the resident did not receive the care required from the PSWs and the follow up by the registered staff related a possible injury and the DOC stated "no, but the investigation isn't over". The DOC verified that the home did not notify the family of the resident's allegation of abuse and neglect. The documentation in the progress notes was reviewed and the DOC stated that allegations of suspected and/or reported abuse and neglect were not to be documented in the resident's progress notes and that it did not maintain the resident's confidentiality of bringing forward a concern. The DOC said the home was doing an investigation for the resident and would discuss the possible submission of a Critical Incident System (CIS) report.

A handwritten note completed by the Quality Manager (QM) stated the resident was interviewed and when the Quality Manager asked the resident questions related to the reported care concerns, the resident denied the incident occurred.

The QM completed "Investigation Interview Forms" for multiple staff. Four PSWs were interviewed as well as a Registered Practical Nurse (RPN) who recalled the resident having a possible injury. The RPN was also documented as stating that the resident did have other physical concerns. One PSW reported an incident where the resident reported a possible physical injury. The PSW then reported it to the RPN who returned to assess, but the resident was already walking down the hallway with no concerns of pain.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to an incident of staff to resident neglect.

The RPN verified that resident complained about physical concerns related to a specific area of the body and that there was a possible injury of this area. The RPN stated they have never completed a pain assessment for the resident. The RPN also stated that they have worked at the home for over a year and this was the first time they heard anything about the resident's concern related to a specific area of the body. The "Investigation Interview Form" completed by the Quality Manager was reviewed with the RPN. The Quality Manager (QM) asked if the resident had voiced complaints of pain and the RPN's reply was documented as "yes" related to the resident's specific area of the body. When asked if there was an assessment completed or documentation of the resident's

complaint of pain on a specific date the RPN replied "no". The RPN verified that the PSWs reported the resident had pain. The Investigation Interview Form also documented that the RPN recalled the resident having a possible injury and the RPN verified that there was no documentation or assessment of the resident's possible injury. The RPN did not know the origin of the possible injury could not recall if there was any follow up with any other team member related to the resident's pain and possible injury.

The Quality Manager (QM) stated the Director of Care (DOC) asked that they take over the investigation of this reported allegation of neglect as the DOC stated they may have compromised the investigation. The QM verified that the resident did not have a pain assessment or documentation completed when the resident complained of pain and did not have a pain assessment completed for several months. The QM also stated that the resident did not report allegations of neglect and denied calling out in pain. The QM also stated there was no documentation or assessment in PCC of the resident's possible injury. The QM acknowledged that the resident first reported the incident to the MOHLTC Inspector and then again to the DOC, but that five days later the resident had no recall of the reported incident when interviewed by the QM. The zero tolerance of abuse policy stated all reported incidents of abuse and/or neglect would be thoroughly and promptly investigated. The QM was asked if the home promptly investigated the reported incident and the QM stated it was initiated promptly, but the investigation and interviews were several days later.

The home did not investigate or document the resident's concerns reported previously related to allegations of abuse by a non-staff member. The home did not immediately investigate the allegations of neglect reported by the resident. The home documented the details of the allegations in the resident's progress notes prior to interviewing the staff, and did not keep the resident's concerns confidential. The staff were interviewed and five days later the resident could no longer recall the incident. The licensee has failed to ensure that every alleged incident of abuse of a resident that was reported to the licensee was immediately investigated and appropriate actions were taken in response. [s. 23. (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 every alleged incident of abuse of a resident that is reported to the licensee is immediately investigated and appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A resident was admitted and developed a possible ulcer within 30 days of admission. The Wound Care Coordinator verified that the resident had acquired altered skin integrity on with 30 days of admission.
The Wound Care Coordinator verified the resident should have been reassessed at least

weekly by a member of the registered nursing staff and was not.

The Wound Care Coordinator stated a "Skin - Weekly Impaired Skin Integrity Assessment - V 4" was to be completed for any altered skin integrity and a "Skin - Weekly Wound Assessment - includes Bates-Jensen - V 6" was to be completed for any resident assessed to have a skin ulcer.

The "Skin and Wound Program: Prevention of Skin Breakdown" policy RC-23-01-01 last updated February 2017 stated the skin and wound program included effective and appropriate skin and wound care treatments and interventions.

The Skin and Wound Program: Wound Care Management policy #RC-23-01-02 last updated February 2017 stated, "a resident exhibiting any form of altered skin integrity, which may include but is not limited to skin breakdown, unexplained bruises, pressure ulcers, skin tears and wounds will be assessed at least weekly by a Nurse, if clinically indicated."

The licensee failed to ensure that when a resident was exhibiting altered skin integrity, that the resident was reassessed at least weekly by a member of the registered nursing staff.

B) A resident was admitted and developed an ulcer within 30 days of admission. The Wound Care Coordinator (WCC) verified that the progress note identified a pressure area and on a Head to Toe Assessment - V 3 identified an open area on admission.

The WCC acknowledged that the resident was not assessed weekly. The Wound Care Coordinator also acknowledged the Skin - Head to Toe Skin Assessment - V3 was completed on a specific date in early 2018 and identified that the resident had compromised skin integrity and there were no other weekly assessment completed for the specific area of the body after this date.

The licensee has failed to ensure that the resident`s altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

The care plan in Point Click Care (PCC) documented specific behaviours for a resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) and documented that the resident had behaviours that put their safety at risk.

The care plan in PCC was updated to include a focus related to the resident`s behaviour and specific interventions to prevent the reported incident from reoccurring.

Three days after the incident an Interdisciplinary Care Conference was held and the summary note in Point Click Care (PCC) documented that the resident required specific environmental controls in place and increased supervision at specific times.

Another CIS report submitted two weeks later documented that the resident had another incident that put the resident’s safety at risk. The long-term actions that were planned to correct this situation and prevent recurrence documented the resident would have an intervention in place related to supervision at specific times. Four days after the incident occurred, the care plan in PCC was updated to include an intervention directing staff related to the increased supervision at specific times. This intervention was discussed at the admission conference and was not added to the care plan until 14 days later.

The Director of Care (DOC) verified that the resident was not supervised as required and the care plan was not updated to include the supervision of the resident until four days after the incident. The DOC verified that actions were not taken to update the care plan, the task in Point of Care (POC) related to frequency of monitoring was not added to the plan of care and the intervention to not leave the resident without supervision was not implemented.

The licensee failed to ensure that strategies were implemented related to specific behaviours demonstrated by the resident and the plan of care was not updated to include interventions related to supervision at specific times. Actions documented as part of the CIS reports were not taken to in order to respond to the needs of the resident. [s. 53. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that symptoms of infection were documented on every shift.

During "stage 1" of the Resident Quality Inspection, an identified resident was noted as having a respiratory infection from the Minimum Data Set (MDS) Assessment.

Review of the MDS quarterly review assessment completed on a specific date, indicated that the resident had a respiratory infection.

Review of the "Monthly Infection Surveillance Form" on a specific date, showed an infection category of respiratory infection for the resident, with a recorded onset date and a resolved date. Review of the Medical Administration Record (MAR) for a specific date, showed that the resident had a treatment of antibiotics initiated on a specific date.

The Registered Practical Nurse (RPN) stated that the resident should have been monitored for symptoms of infection on each shift and that symptoms were to be

documented under in the progress notes in Point Click Care (PCC).

Record review of the progress notes in PCC showed documentation of infection for the resident, for a specific date range, showed that 30 out of 39 (77 per cent) shifts did not have documentation of the symptoms of infection for the resident. There were no further progress notes documenting symptoms of infection on each shift in PCC for the specific date range.

The Registered Nurse (RN) stated that the resident was identified and monitored as having a respiratory infection for a specific date range. The RN stated that the resident should have been monitored for symptoms of infection on each shift and that symptoms were to be documented under the progress notes in PCC. When asked by the inspector if symptoms of infection were documented elsewhere, the RN said no, just in the progress notes.

The Director of Care (DOC) confirmed that the resident was diagnosed with a respiratory infection on a specific date, as per the resident's progress notes in PCC. The DOC said that the expectation was that documentation for daily monitoring of infection was to be completed as a progress note in PCC on every shift. The DOC reviewed the dates of documentation in the progress notes on PCC for the resident, and they acknowledged that the documentation was missing and should have been completed on each shift. When asked if the home had a policy to indicate that symptoms of infections are to be documented on each shift, the DOC acknowledged it was the policy titled Infection Surveillance and Control, last updated September 2016.

A review of the home's policy titled Infection Surveillance and Control, last updated September 2016, stated the following:
"Required Documentation: Daily 24-Hour Symptom Surveillance Form – use to track symptoms on a day-to-day basis to ensure regular follow-up and also to help identify a potential outbreak."

Review of the Daily 24-Hour Symptom Surveillance Form (Mandatory) on a specific date, for the resident showed symptom documentation on a specific shift. There were no additional Daily 24-Hour Symptom Surveillance Forms completed for the resident, which documented symptoms of infection on each shift for a specific date range.

The Acting Director of Care (ADOC) was asked if the home had a policy which indicated that symptoms of infections are to be documented on each shift. The ADOC reviewed the

Infection Surveillance and Control policy and stated that registered staff are to complete the Daily 24-Hour Symptom Surveillance Form (Mandatory), which indicated documentation shifts as "Days", "Afternoons" and "Nights". When asked if the ADOC's expectation was that registered staff were to document symptoms of infection for each shift on the Daily 24-Hour Symptom Surveillance Form (Mandatory) as per policy, the ADOC said, "yes".

The licensee has failed to ensure that the symptoms of infection for the resident were documented on every shift. [s. 229. (5) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that symptoms of infection are documented on every shift, to be implemented voluntarily.

WN #7: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the licensee was required to ensure that the policy was complied with.

In accordance with O. Reg. 79/10, s.30 (1), the licensee was required to ensure that the

following was complied with in respect of each of the organized programs required under section 48 of this Regulation: "there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Section 48 of O. Reg. 79/10 states “every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury."

On a specific date, the home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care which identified a fall resulting in an injury for a specific resident.

The Incident Report under Risk Management in Point Click Care (PCC) for the resident showed documentation for a falls risk incident, with a specific incident date and time. The incident stated that the resident was found in a specific position on the floor. The incident report stated that there were no witnesses of the fall.

The progress notes in PCC on a specific date, stated that the resident had no Head Injury Routine (HIR).

A Registered Nurse (RN) stated that if a fall was unwitnessed, the resident should be started on a Head Injury Routine (HIR), which is documented on a Clinical Monitoring Record. The inspector asked for the documentation of the Clinical Monitoring Record for the residents' fall on a specific date. The RN reviewed the clinical records for the resident and stated that the HIR assessment was not completed. The RN acknowledged that the incident was unwitnessed and that the Clinical Monitoring Record for HIR should have been completed. When asked if the home had a policy to indicate procedures for an unwitnessed fall, the RN provided the inspector with the Falls Prevention and Management Program policy #RC-15-01-01, last updated February 2017.

The Falls Prevention and Management Program policy #RC-15-01-01, last updated February 2017, stated the following under Post Fall Management:
- “If a resident hits head or is suspected of hitting head (e.g., unwitnessed fall) complete Clinical Monitoring Record, Appendix 10.”

The General Manager (GM) acknowledged that the resident fell on a specific date, was

unwitnessed. The inspector asked the GM if according to the Falls Prevention and Management Program policy, that staff should have completed the Clinical Monitoring Record for the residents' unwitnessed fall, the GM stated that it would be their expectation, of course.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure the licensee was, that the policy and procedure was complied with for the resident. [s. 8. (1) (a),s. 8. (1) (b)]

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 had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On a specific date, the home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care which identified a fall resulting in an injury for a specific resident.

Review of Risk Management in Point Click Care (PCC) for the resident showed the following:
-Incident on a specific date and time.
-Incident on a specific date and time.
-Incident on a specific date and time.

A Registered Nurse (RN) stated that a post fall assessment was to be completed after every fall, witnessed or unwitnessed. The RN stated that the registered staff complete an incident report under Risk Management in PCC and that the post fall assessment was documented in PCC under Assessments.

Review of the Post Fall Assessments in PCC for the resident were stated as follows:
- Falls Management - Post Fall Assessment was documented as completed on a specific date
- Falls Management - Post Fall Assessment was documented as completed on a specific date

The General Manager (GM) stated that after a resident had fallen, a post fall assessment was to be completed. The General Manager reviewed Risk Management and Assessments in PCC for the resident and acknowledged that there was no post fall assessment completed for a fall on a specific date. The GM stated that the expectation would be that a post fall assessment should have been completed for each fall incident for the resident.

The Falls Prevention and Management Program policy #RC-15-01-01, last updated February 2017, stated the following under Post Fall Management:
"Hold a Post-Fall Huddle, ideally within the hour and complete a post-fall assessment as soon as possible".

The licensee has failed to ensure that when the resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [s. 49. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Medication Incident Report documented that an incorrect dose of a specific medication was administered to a resident. The order was transcribed into the Point Click Care (PCC) electronic Medication Administration Record (eMAR) incorrectly and the evening Registered Nurse confirmed that the resident was not administered the dose as ordered.

The Director of Care (DOC) acknowledged that the resident was administered the incorrect dose of a medication.

The licensee has failed to ensure that the medication was administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 1st day of August, 2018

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

Original report signed by the inspector.