Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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 13, 2015	2015_205129_0001	T1590-14	Critical Incident System

Licensee/Titulaire de permis

NORTH YORK GENERAL HOSPITAL
4001 LESLIE STREET NORTH YORK ON M2K 1E1

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

SENIORS' HEALTH CENTRE
2 BUCHAN COURT NORTH YORK ON M2J 5A3

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

PHYLLIS HILTZ-BONTJE (129), AMANDA WILLIAMS (101), SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 21,23, 27, 28 and February 5, 2015.

During the course of the inspection, the inspector(s) spoke with the resident's son, daughter and sister, Administrator, Director of Care, Assistant Director of Care, Social Worker, Respiratory Technician, Physiotherapist, Registered and unregulated nursing staff, Physician, hospital human resource staff,and the Private Care Provider
The inspector also reviewed clinical as well as home policies and procedures, observed and tested the oxygen concentrator alarm, observed the procedure for the use of auxiliary power during power outages and reviewed staff files.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

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. 87. Emergency plans

Specifically failed to comply with the following:

s. 87. (2) Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations. 2007, c. 8, s. 87. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that emergency plans for the home are tested, evaluated, updated and reviewed with the staff of the home.

Interviews with the Administrator, Director of Care, Environmental Supervisor, the home's educator, and reception revealed that staff have not conducted tests in emergency plans annually or at least once every three years for identified emergencies as outlined in the regulation. [s. 87. (2)]

2. Interviews with Administrator and Environmental Supervisor and record review confirmed that the home has not evaluated or updated the emergency plans in the home to be home specific since the change in management from Speciality Care to Leisureworld. [s. 87. (2)]

3. There are no emergency plans in place that are home specific and available to staff at the time of inspection. [s. 87. (2)]

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #001 from neglect when inaction by staff jeopardized the resident's health and well being, in relation to the following: [19(1)]
a) In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff who did not ensure a therapy identified as required on a continuous basis by resident #001 remained functioning during and following a power outage. This inaction jeopardized the health of the resident.
-Resident #001 was admitted to the home in July 2014 and required the use of a therapy

machine on a continuous 24 hour bases in order to manage two identified medical conditions
-On an identified date the resident was transferred to hospital due to a deterioration in the resident's condition. Assessments conducted in hospital identified that the resident also suffered from another co-related medical condition and hospital physicians ordered the resident to receive a second identified therapy machine that required electrical power, during specific times in each 24 hour period in order to manage this condition.
-The resident returned to the home nine days later with directions for the use of this new therapy and the following day a contracted service provider executed the set-up of this equipment.
-Two months following the last hospital admission staff were having difficulty stabilizing the resident's condition and both the Respiratory Technician (RT) and the resident's physician determined that the resident required the use of both therapy machines on a continuous 24 hour basis.
-Approximately two months later the home experienced an electrical power failure that required staff to connect two extension cords from the resident's room down the hall to a generator supplied power outlet and then connect the resident's therapy machines in order to ensure the resident received these therapies. Staff were called to the resident's room three hours after the brief power failure where the Registered Nurse (RN) who responded found the resident with vital signs absent. This RN confirmed both in writing and verbally that when she looked at the electrical power source the resident's therapy machine was not connected to the power source and was not functioning.
The licensee did not ensure that staff took action to ensure the therapy equipment the resident required on a continuous basis maintained operational status during and following an electrical power outage and this inaction jeopardized the resident's health and well-being.

b) In accordance with the definition of neglect identified in O. Reg. s. 5, a pattern of inaction by staff in the assessment and management of responsive behaviours being demonstrated by resident #001 relating the use of therapy equipment jeopardized the health of the resident.
- During a hospital admission for assessment of a worsening condition in August 2014, it was determined that the resident had an untreated medical condition that was identified as contributing to the resident's worsening condition. The resident was treated in hospital with a specific therapy machine to manage this newly identified condition. Directions included in the discharge note and received by the home when the resident was discharged from the hospital indicated the resident was to use the identified therapy

machine during specific times over each 24 hour period.
- Resident #001 began demonstrating responsive behaviours related to the use of the identified therapy machine and 12 days after the resident returned from hospital the resident disclosed to the Respiratory Technician (RT) that the therapy machine had not been used since it was set up 11 days previously. The following day the RT documented that the resident indicated staff do not respond to calls on the nurse call system, the resident was fearful if the therapy machine was removed there would not be a staff person to connect the primary therapy machine that the resident required continuously and the resident was fearful of passing out. Clinical documentation confirmed the therapy machine ordered to be used by the resident during specific times over each 24 hour period had not been used eight times during this 11 day period and for three of the 11 days there was no documentation to indicate if the therapy machine had been used. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified responsive behaviours or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 11 day period.
-The responsive behaviour continued and the resident was admitted to hospital 25 days later with the same worsening condition. A follow-up after discharge comment written by the hospital physician and received by the home indicated the resident's family physician was to ensure the resident was receiving therapy treatments as ordered and the hospital physician indicated that nursing staff at the home were contacted to identify the importance of the resident receiving this therapy as it was ordered. Clinical documentation confirmed that in the 25 days between the resident's disclosure to the RT and this hospital admission the therapy machine had not been used 17 times and for eight of the 25 days there was no documentation to indicate the therapy machine had been used. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified responsive behaviour or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 25 day period.
- Twenty four days after the previous hospital admission for worsening condition, clinical documentation indicated the resident was again demonstrating signs and symptoms of the same worsening condition. The physician was notified and directed staff to increase the concentration of the continuous therapy and also requested Respiratory Services assess the resident. Clinical documentation indicated the RT saw the resident, treated the resident with the use of the second therapy machine which improved the resident's condition, communicated to staff that the resident was to use the second therapy machine continually through the night and that they would be back the next morning to

assess the resident. The following day the RT documented that a family member of the resident was contacted and at the time it was suggested that the resident's family member contact the Community Care Access Centre in order to purchase private care to assist the resident with the use of the therapy machines. In the preceding 20 days since the resident returned from hospital the clinical record confirmed that the therapy machine that was ordered to be used during specific times over each 24 hour not been used for 11 of those times and for eight of the 20 days there was no documentation in the clinical record that would indicate the therapy machine was used . Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the responsive behaviour or address the anxiety and fear the resident was experiencing related to staff’s responses to calls for assistance in order to ensure the resident received the required treatment over this 20 day period.
- Twenty two days after the previous episode of worsening condition the resident called Emergency Medical Services (EMS). Clinical notes indicated that both police and EMS workers responded to this call and the resident indicated to police and EMS that they were experiencing signs and symptoms of the same worsening condition and also expressed their concern that staff at the nursing home was doing nothing to address this issue. Clinical documentation indicated that EMS workers assessed the resident as having signs and symptoms of the same worsening condition and recommended the resident be transferred to hospital for further assessment and treatment. The resident was admitted to the hospital and both of the exiting therapy machines were initiated in order to improve the resident's condition. Admission notes written by the hospital physician and provided to the home indicated that the only thing the hospital could do during this admission was ensure proper use of the therapy machines ordered two and a half months previously. In the 19 days since the resident returned from the last hospital admission and this hospital admission the clinical record confirmed that for 13 of those days the therapy machine ordered to be used during specific times over each 24 hour period had not been used and for three of the 19 days there was no documentation in the clinical record that would indicate the therapy machine was used. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified responsive behaviour or address the anxiety and fear the resident was experiencing related to staff’s responses to calls for assistance in order to ensure the resident received the required treatment over this 19 day period.
- Approximately a month after the previous hospital admission resident #001 was found with vital signs absent and over the 25 days between the resident’s return to the home from the previous hospital admission and the resident’s death the clinical record confirmed that for 13 of those days the therapy machine that was ordered to be used during specific times over each 24 hour period had not been used and for nine of the 25

days there was no documentation in the clinical record that would indicate the therapy machine was used. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified responsive behaviour or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 25 day period.
- A pattern of inaction by staff in the assessment and management of the resident's identified responsive behaviour related to the use of the therapy machine and the residents fear and anxiety related to staff not responding to calls for assistance resulted in the resident not receiving the required treatment which jeopardized the resident's health and well-being. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's right not to be neglected was fully respected and promoted in relation to the following:[3(1)3]
a) In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff who did not ensure the therapy equipment identified as required by this resident on a continuous basis remained functioning during and following a power outage. This inaction jeopardized the health of the resident.
- On an identified date the home experienced an electrical power failure that required staff to run two extension cords from the resident's room down the hall to a generator supplied power outlet and then connect the resident's electrical therapy equipment to the extension cord. Staff were called to the resident's room approximately two and a half

hours after the brief power failure and the Registered Nurse (RN) who responded found the resident with vital signs absent. This RN confirmed both in writing and verbally that when she looked at the electrical power source the resident's therapy equipment was not connected to the power source and was not functioning.

b) In accordance with the definition of neglect identified in O. Reg. s. 5, a pattern of inaction by staff to address and manage both the identified responsive behaviour being demonstrated by the resident and the anxiety and fear the resident experienced in relation to staff not responding to calls for assistance contributed to the resident not receiving required treatment to manage a identified medical conditions. This pattern of inaction jeopardized the health of the resident.
- During a hospital admission for assessment of a worsening condition in August 2014, it was determined that the resident had an untreated medical condition which was identified as a contributing factor to Resident #001's worsening condition. The resident was treated in hospital with the use of a therapy machine. Directions included in the discharge note, received by the home, indicated the resident was to use this therapy machine during specific times in each 24 hour period.
-Resident #001 began demonstrating responsive behaviours related to the use of the therapy machine when on an identified date the resident disclosed to the Respiratory Therapist (RT) that the therapy machine had not been used since it was set up 11 days previously. The following day the RT documented that the resident indicated staff do not respond to calls on the nurse call system, the resident was fearful if the therapy machine is removed there would not be a staff person to connect therapy machine the resident required continuously and the resident was fearful of passing out.
-Over the next three months the resident continued to demonstrate the identified responsive behaviours related to the use of the therapy machine that was ordered to be used during specific times over each 24 hour period. Staff and the clinical record confirmed that at no time during this three month period of time did staff take action to assess the behaviours being demonstrated by the resident, there had been no attempt to identify triggers for this behaviour, no strategies had been developed or implemented to respond to this behaviour in order to ensure the resident received the required therapy and there was no documentation of this behaviour. [s. 3. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that resident's right not to be neglected by staff is fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident, in relation to the following: [6(1)(c)]
Resident #001's written plan of care did not set out clear directions in relation to the use of the therapy machine that the physician had ordered to be used during specific times in every 24 hour period. Directions contained in hospital discharge note provided to the home and included in the resident's clinical record directed that the resident was to use a specific therapy machine during specific times during each 24 hour period. Those directions conflicted with the written directions for staff providing care to the resident that

indicated the resident would ask for the therapy machine when needed to manage specific symptoms. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, in relation to the following: [6(10)(b)]
a) Resident #001's plan of care was not reviewed or revised when the resident began demonstrating responsive behaviours related to the use of therapy equipment. During a hospital admission due to a deteriorating condition, it was determined that the resident required a therapy treatment for a newly identified medical condition. Clinical documentation indicated that the resident was refusing the treatment due to fear staff would not respond to calls for assistance, if the therapy machine was removed there would not be staff to connect the continuous therapy the resident required and the resident was fearful of passing. Staff and clinical documentation confirmed that staff providing care were aware of the behaviour and the resident's plan of care was not reviewed or revised to include this behaviour and care strategies to manage the behaviour.
b) Resident #001's was not reassessed when the resident's care needs changed in relation to pain and pain management. The resident's physician made several changes to the quantity and frequency of both regularly scheduled and as necessary narcotic analgesic over a three month period of time. Staff and the clinical record confirmed that staff had not completed a reassessment of the resident's needs in relation to pain management throughout this period of time. Significant differences were noted in the data collected during an admission pain assessment completed in July 2014 and data collected on a pain assessment completed four months later when it was identified that the resident was now experiencing pain, the severity of the pain experienced by the resident changed from mild to horrible and excruciating and the type of pain being experienced changed from hammering and sharp to hammering, sharp, stabbing and shooting. The Acting Assistant Director of Care and clinical documentation confirmed that following the data collection event in July 2014 and the following data collection event four months later staff did not complete an assessment and analysis of the data collected in relation to the changing needs of the resident.
c) Resident #001's plan of care was not reviewed or revised in relation to the risk for skin ulceration and bed mobility. Care directions for staff in relation to the risk for skin ulceration developed in August 2014 and bed mobility developed in September 2014 directed staff that the resident was on a turning and positioning program and staff were to provide total care in turning and positioning the resident every two hours. At the time of this inspection staff and clinical documentation confirmed that due to a pre-existing

condition the resident was only comfortable lying in one position; however, the resident's plan of care was not reviewed or revised to include alternate pressure relieving and positioning strategies for this resident. [s. 6. (10) (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 and ensuring compliance with s. 6(1)(c) and 6(10)(b) of the Act, to be implemented voluntarily.

WN #5: 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 failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol or procedure that staff complied with the plan, policy, protocol or procedure, in relation to the following: [8(1) (b)]
1. Staff did not comply with directions contained in the "Pain and Symptom Assessment and Management Protocol" identified as #VII-G-70.00 and dated 2013.
-This protocol directed staff to initiate a 24hr Pain and Symptom Management Tool when the resident's pain remains regardless of the interventions. Resident #001 experienced ongoing pain and was being treated with regularly scheduled and as necessary narcotic analgesic medication. Staff confirmed that the resident would regularly request additional analgesic outside the schedule of analgesic administration ordered by the resident's

physician and that they felt the resident's pain was not being managed based on the interventions in place. Staff and clinical documentation confirmed that this direction was not complied with when a 24hr. Pain and Symptom management Tool was not initiated when the resident indicated that the pain being experienced remained despite the interventions in place.
- This protocol directed staff to initiate, communicate, review and evaluate the plan of care daily with the interdisciplinary team to address each resident's pain. Staff and clinical documentation confirmed that this direction was not complied with when there were not regular reviews and evaluations of resident #001 plan of care related to pain management by the interdisciplinary team.
-This protocol directed staff to review, evaluate and document weekly resident outcome pain management notes. Staff and clinical documentation confirmed that this direction was not complied with when there were no regular reviews and evaluations of resident #001's pain management outcomes documented in the clinical record.
-This protocol directed that Physiotherapy (PT) carry out a system assessment as appropriate for musculoskeletal and neurological conditions and contributing pain factors. The PT confirmed that a referral had been submitted requesting PT to become involved in the management of pain being experienced for resident #001. The PT confirmed that this direction was not complied with when an assessment of the resident related to pain was not completed.

2. Staff did not comply with the directions contained in the Continuous Positive Airway Pressure (CPAP)/Bi-Level Intermittent Positive Airway Pressure (BIPAP) Equipment policy included in the nursing service program and identified in the home's policy "CPAP/BIPAP Policy" identified as #VII-G-30.10 and dated April 2011.
- This policy directed the Registered Nurse (RN) or Registered Practical Nurse (RPN) to obtain a doctor's order which included specifics for use and frequency of use upon learning of the resident's need to use this equipment. Staff did not comply with this direction when they became aware that resident #001 required the use of this equipment on following an assessment by the Respiratory Technologist (RT) on August 20, 2014.
3. Staff did not comply with the directions contained in the "Responsive Behaviours" policy, identified as # VII-F-30.00 and dated September 2013.
- This policy directed registered staff to conduct and document a responsive behaviour assessment when a resident demonstrates responsive behaviours. Staff and clinical documentation confirmed that when resident #001 began demonstrating an identified responsive behaviour that this responsive behaviour was not assessed.
4. Staff did not comply with the directions contained in the "Private Caregivers and Companion" policy, identified by #VII-C-50.00, dated January 2013 and included in the

Nursing and Personal Support Services program.
-This policy directed that all Private Caregivers must be registered with the Director of Care's office by completing a registration package. During the course of this inspection the name, contact information and qualifications of the private care providers were not available. The Director of Care (DOC) confirmed that this policy was not complied with when the private caregivers providing care to resident #001 were not registered with the DOC and these care givers did not receive the identified registration package.
-This policy directed that a "Designated Duties of a Private Caregiver" form shall be completed, signed by the Resident/Hirer and forwarded to the DOC. The DOC confirmed that staff did not ensure the Designated Duties of a Private Caregiver form was completed by those persons providing private care to resident #001 and as a result, staff in the home was not able to indicate what care was actually to be provided by the private caregivers.
-This policy directed that the Administrator will ensure that a file of the stated information for each individual private caregiver is maintained by the Office Manager alongside the resident's business file. The DOC confirmed that the stated information was not obtained and was not available in the home.
-This policy directed that the DOC will ensure that a list of private caregivers and contact numbers was to be maintained on the appropriate home area. The DOC confirmed that this policy was not complied with when it was identified that the home did not know the names or contact information for private caregivers providing care to resident #001. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol or procedure that staff complied with the plan, policy, protocol or procedure,, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 20. (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 failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents that contained an explanation of the duty under section 24 to make mandatory reports, in relation to the following: [20(d)]
The policy provided by the home "Abuse and Neglect of a Resident – Actual or Suspected", identified as #VII-G-10.00 and dated March 2012 did not contain an explanation of the duty under section 24 to make mandatory reports. This policy directed that the Administrator or designate will notify the MOHLTC immediately according to protocols established for the reporting of abuse and critical incidents, but does not contain an explanation of the duty to report. The attached checklist "Abuse and Neglect of a Resident-Actual or Suspected Nursing Checklist" identified as #VII-G-10.00 also did not contain an explanation of the duty to make mandatory reports. Three of three professional staff interviewed confirmed that they were not aware of the mandatory reporting requirements identified in section 24 of the Act. [s. 20. (2) (d)]

2. The licensee failed to ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents dealt with additional measures provided for in the regulations, in relation to the following: [20(2) (h)]
a) The policy provided by the home "Abuse and Neglect of a Resident – Actual or Suspected", identified as #VII-G-10.00 and dated March 2012 did not deal with the requirement specified in O. Reg. 79/10, s. 96(c) when this policy did not identify measures and strategies to prevent abuse and neglect of residents.
b) The policy provided by the home "Abuse and Neglect of a Resident – Actual or Suspected", identified as #VII-G-10.00 and dated March 2012 did not deal with the requirement specified in O. Reg. 79/10, s. 96(e)(i) when this policy did not identify training and retraining requirements for all staff, including, training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. This policy also did not deal with the requirement specified in O. Reg. 79/10, s. 96(e)(ii) when this policy did not identify training and retraining requirements for all staff, including situations that may lead to abuse and neglect and how to avoid such situations. [s. 20. (2) (h)]

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 compliance with section 20(2)(d) and 20(2)(h) of the Act,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to responsive behaviours were developed, in relation to the following: [53(1)2]
The policy provided by the home titled "Responsive Behaviours", identified as # VII-F-30.00 and dated September 2013 did not include required written strategies related to techniques and interventions to prevent and minimize responsive behaviours. [s. 53. (1) 2.]

2. The licensee failed to ensure that at least annually written approaches to care, including screening protocols, assessment, reassessment, identification of behavioural triggers that may result in responsive behaviours, written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours as well as resident monitoring and internal reporting protocols for residents demonstrating responsive behaviour was completed, in relation to the following: [53(3)(b)]
The Administrator confirmed that an annual evaluation was not completed of the written approaches to care, resident monitoring, internal reporting protocols and referring protocols for residents demonstrating responsive behaviours. [s. 53. (3) (b)]

3. The licensee failed to ensure that behavioural triggers were identified, strategies were developed and implemented to respond to behaviours and actions were taken to respond to the needs of resident #001 when this resident demonstrated responsive behaviours over a four month period of time, in relation to the following: [53(4)(a)(b)(c)]
Resident #001 began demonstrating responsive behaviours due to fear that staff would not provide the care required related to the use of therapy equipment required by the resident.
- On an identified date the resident disclosed to the Respiratory Therapist (RT) that the therapy machine had not been used since it was set up 11 days previously. The following day the RT documented that the resident indicated staff do not respond to calls on the nurse call system, the resident is fearful if the therapy machine was removed there would not be a staff person to connect the continuous therapy machine and the resident is fearful of passing out. The clinical record confirmed that the therapy machine had not been used eight times during this 11 day period and for three of the 11 days there was no documentation to indicate the therapy machine had been used. Staff and the clinical record confirmed that the resident was not assessed, there had been no attempt to identify triggers for this behaviour, no strategies had been developed or implemented to respond to this behaviour in order to ensure the resident received the required treatment and there was no documentation of this behaviour.
- The resident's responsive behaviour continued and the resident was admitted to

hospital on an identified date. The clinical record confirmed that in the preceding 25 days to this hospital admission the therapy machine had not been used 17 times and for eight of the 25 days there was no documentation to indicate the therapy machine had been used. Staff and the clinical record confirmed that the resident was not assessed, there had been no attempt to identify triggers for this behaviour, no strategies had been developed or implemented to respond to this behaviour in order to ensure the resident received the required treatment and there was no documentation of this behaviour.
-The resident's responsive behaviour continued and the resident began demonstrating signs and symptoms of the medical condition the therapy machine was to manage. The physician was notified and directed staff to increase the concentration of the continuous therapy machine the resident and requested that Respiratory Services assess the resident. Clinical documentation indicated that Respiratory Services saw the resident, treated the resident with the use of both the continuous therapy and the second therapy machine which improved the resident's condition. The following day the RT documented that a family member of the resident was contacted and it was suggested that the resident's family member contact the Community Care Access Centre in order to purchase private care to assist the resident with the use of the therapy machines. In the preceding 20 days since the resident returned from hospital the clinical record confirmed that the therapy machine was not used for 11 of those days and for eight of the 20 days there was no documentation in the clinical record that would indicate the therapy machine was used. Staff and the clinical record confirmed that the resident was not assessed, there had been no attempt to identify triggers for this behaviour, no strategies had been developed or implemented to respond to this behaviour in order to ensure the resident received the required treatment and there was no documentation of this behaviour.
- The resident's responsive behaviour continued and 22 days later the resident was again transferred to hospital when the resident called Emergency Services due to a worsening of the same medical condition and the concern that staff at the nursing home were doing nothing to address this issue. Clinical documentation indicated the resident was admitted to the hospital to be put on the therapy machine to improve this medical condition. In the 19 days since the resident returned from the last hospital admission and this hospital admission the clinical record confirmed that for 13 of those days the therapy machine was not used and for three of the 19 days there was no documentation in the clinical record that would indicate the therapy machine was used. Staff and the clinical record confirmed that the resident was not assessed, there had been no attempt to identify triggers for this behaviour, no strategies had been developed or implemented to respond to this behaviour in order to ensure the resident received the required treatment and there was no documentation of this behaviour.

- The resident's responsive behaviour continued and over the 25 days between the resident's return to the home from the previous hospital admission and the resident's death in December 2014 the clinical record confirmed that for 13 of those days the therapy machine had not been used and for nine of the 25 days there was no documentation in the clinical record that would indicate the therapy machine was used. Staff and the clinical record confirmed that the resident was not assessed, there had been no attempt to identify triggers for this behaviour, no strategies had been developed or implemented to respond to this behaviour in order to ensure the resident received the required treatment and there was no documentation of this behaviour. [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 compliance with section 53(1)2, 53(3)(b), 53(4)(a)(b)(c), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that retraining in emergency and evacuation procedures is conducted on an annual basis.

Interview with the Administrator, Environmental Supervisor, Office Manager, reception, front-line nursing staff and the Educator revealed that retraining in emergency and evacuation procedures has not been conducted on an annual basis. This was also confirmed by record review of completion of online training modules. [s. 219. (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 and ensure that all staff receive training and re-training in emergency and evacuation procedures that are home specific, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that persons who worked at the home pursuant to a third party agreement in accordance with clause (c) of the definition of "Staff" where provided with information in the area of the Residents' Bill of Rights, the long term care home's policy to promote zero tolerance of abuse and neglect of resident, the duty under section 24 to make mandatory reports, the protection afforded by section 26, fire prevention and safety, emergency and evacuation procedures as well as infection prevention and control, in relation to the following: [222(2)]
A private duty personal support worker (PSW) contracted by the resident confirmed that the home did not provide information related to the Residents' Bill of Rights, the long term care home's policy to promote zero tolerance of abuse and neglect of resident, the duty under section 24 to make mandatory reports, the protection afforded by section 26, fire prevention and safety, emergency and evacuation procedures as well as infection prevention and control at any time prior to providing care to resident #001 or during the period of time she provided care to the resident. The Director of Care confirmed that an orientation related to the requirements in this regulation was not provided to private duty staff contracted by the resident to provide care. [s. 222. (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 and ensuring compliance with section 222(2)of the regulations, to be implemented voluntarily.

WN #10: 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. Persons who had reasonable grounds to suspect that improper or incompetent care of a resident and abuse of a resident had occurred failed to immediately report the suspicion and the information upon which it is based to the Director, in relation to the following: [24(1)(2)]
1. A Registered Nurse (RN) and a Social Worker (SW) who had reasonable grounds to suspect that resident #001 had received improper or incompetent care that resulted in a risk of harm to the resident did not immediately report this information to the Director. [24(1)1]
(a) On an identified date the RN and the Acting Assistant Director of Care confirmed that they connected resident #001's electrical equipment, which included therapy equipment,

which the resident required on a continuous basis to auxiliary power when the home experienced a power outage. Approximately two and a half hours after a brief power failure the RN was called to see resident #001 by a Personal Support Worker (PSW). The RN indicated that when she entered the room the resident's skin was grey coloured and no respiration or heart beat were detected. During an interview conducted on January 14, 2015 and in a written statement provided to the home, the RN confirmed that when she entered the resident's room the therapy machine required by the resident to be used continually was not working. The RN confirmed that she investigated this situation and found that this equipment was not plugged into a power source and at the time she was very upset about this and asked who had unplugged the equipment. The RN also confirmed that she felt the circumstances under which she found the resident were suspicious, that she was not aware of the mandatory reporting requirements in the Long Term Care Homes Act and that she did not report the suspicious circumstances she identified in accordance with the Act.
(b) A Social Worker (SW) confirmed that on an identified date the RN asked her to come with her to assess resident #001. The SW indicated when she entered the room she noted the resident was pale and the resident felt cold when touched. The SW confirmed that at this time the RN indicated the resident had passed and that the therapy equipment required to be used continually by the resident was not properly connected to the power source. When asked if she felt the circumstances that were noted in the resident's room were suspicious she indicated that she felt they were, particularly because the RN appeared so shocked at finding the therapy equipment unplugged. The SW confirmed during an interview on January 20, 2015, that at the time she thought that there may have been a connection between the therapy equipment not being connected to a power source and the resident's passing. When asked if she reported her suspicion to anyone she confirmed that she did not because she felt it would be up to the RN to make any judgements about reporting. The SW indicated she was not certain about the requirements in the Act related to mandatory reporting, but after reading the section 24 of the Act she indicated that she should have reported this situation to the Ministry.

2. A Registered Practical Nurse (RPN) who had reasonable grounds to suspect that resident #001 had been place at risk of harm by what she considered abusive care did not immediately report this information to the Director. [24)(1)2]
- The RPN and clinical documentation confirmed that 0n an identified date resident #001 called the RPN to the room and indicated they had a complaint about a PSW's care. The resident described to the RPN that a PSW had come into their room and made the resident's phone fall on the floor and when the resident asked this PSW to pick the phone up the PSW told the resident there was nothing on the floor but a paper cup. At

this same time the resident indicated to the RPN that they asked the PSW to put the call bell with the light string attached in their hand and the PSW responded by telling the resident it was behind them. The RPN documented that when she checked the resident the call bell was on the floor behind the resident and the resident's phone was hanging by the cord an inch from the floor. When asked how she felt about the complaint the resident was making she responded by saying "this is not a hard thing to do to give the resident these things, the phone was the only tool the resident had to communicate with their family and the call bell was the only way they could communicate with the staff". The RPN confirmed that the actions of the PSW were particularly disturbing based on the medical issues for this resident and the resident's requirements to have staffs assistance with all of the activities of daily living. During this interview the RPN appeared upset when describing this situation and when asked if she felt this would constitute resident abuse she confirmed that she felt this was abusive and that the resident was helpless. The RPN confirmed that she did not report this situation to anyone and felt that because she was documenting it in the clinical record that this would be read by the administrative staff in the morning. The RPN was asked if she was familiar with the mandatory reporting requirements in the Long Term Care Homes Act and she responded by saying "not really". After reading section 24 of the Act she indicated this was something that should have been reported should have been reported to the Director. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. 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. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the pain management program required under O. Reg. 79/10, s. 48(1)4 was evaluated at least annually, in relation to the following: [30(1)3] The Administrator confirmed that an annual evaluation of the Pain Management Program was not completed. [s. 30. (1) 3.]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg.79/10 s. 219(1) in the area of pain management in accordance with O. Reg. s. 221(4), related to the following: [76(7)6]
The licensee provided information that indicated 126 staff in the home provided direct care to residents. The licensee was unable to provide any documentation to indicate that any of the 126 staff who provided direct care to residents received training in the area of pain management in 2014. [s. 76. (7) 6.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, in relation to the following: [98]
The Director of Care (DOC) confirmed that the circumstances identified subsequent to the death of resident #001 were suspicious and that police were not notified of these circumstances. On December 15, 2014 resident #001 was found with absent vital signs and the resident's therapy equipment was noted to be unplugged from an electrical power source and not functioning. The DOC and clinical documentation confirmed that this resident required the continuous use of this therapy equipment in order to manage a serious medical condition. [s. 98.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, in relation to the following: [99(b)]
The Administrator confirmed that an annual evaluation was not made to determine the effectiveness of the home's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents. [s. 99. (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstance of an unexpected or sudden death, including a death resulting from an accident or suicide, in relation to the following: [107(2)]
The Administrator and Director of Care confirmed that they did not immediately inform the Director of the sudden death of resident #001 or the circumstances of this death. The Director of Care became aware of circumstances related to the death of resident #001 two days following the resident's death when a registered nurse provided the Director of Care with a written statement indicating that the resident's therapy equipment was not functioning at the time of the resident's death. The resident's physician and registered staff providing care to the resident confirmed that the resident's death was sudden. [s. 107. (1) 2.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the training and orientation program was evaluated and updated, in relation to the following: [216(2)]

The Administrator confirmed that annual evaluations of the training and orientation program had not been completed. [s. 216. (2)]

Issued on this 9th day of April, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), AMANDA WILLIAMS (101), SUSAN SQUIRES (109)
Inspection No. / No de l'inspection :	2015_205129_0001
Log No. / Registre no:	T1590-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 13, 2015
Licensee / Titulaire de permis :	NORTH YORK GENERAL HOSPITAL 4001 LESLIE STREET, NORTH YORK, ON, M2K-1E1
LTC Home / Foyer de SLD :	SENIORS' HEALTH CENTRE 2 BUCHAN COURT, NORTH YORK, ON, M2J-5A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sara Rooney

To NORTH YORK GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 87. (2) Every licensee of a long-term care home shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in the regulations. 2007, c. 8, s. 87. (2).

Order / Ordre :

The licensee shall ensure that all emergency plans are developed, updated, reviewed and the following plans tested
a) Annually: in addition to loss of one or more essential services and fire, situations involving a missing resident, medical emergencies and violent outbursts
b) Once every 3 years: community disasters, bomb threat, and chemical spills.

Grounds / Motifs :

1. There are no emergency plans in place that are home specific and available to staff at the time of inspection. (101)

2. Interviews with Administrator and Environmental Supervisor and record review confirmed that the home has not evaluated or updated the emergency plans in the home to be home specific since the change in management from Speciality Care to Leisureworld. (101)

3. Interviews with the Administrator, Director of Care, Environmental Supervisor, the home's educator, and reception revealed that staff have not conducted tests in emergency plans annually or at least once every three years for identified emergencies as outlined in the regulation. (101)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare submit and implement a plan to ensure residents who require the use of electrically powered equipment to meet their care needs and residents who are demonstrating responsive behaviours are protected from neglect, in relation to these needs, by the licensee or staff.
The plan is to include, but is not limited to the following:
1. The development and implementation of a system to review all residents in order to identify those residents who are dependent on the use of electrically powered equipment to meet their care needs.
2. The development of resident specific plans of care that provide clear direction to staff regarding the steps to be taken to ensure that the electrical equipment required by the identified residents is to be kept functioning during and following power outages.
3. The development of a schedule to test and monitor staff's performance in implementing the plans of care for residents who are dependent on electrical equipment to meet their care needs
4. The development and implementation of a protocol staff are to follow including assessment, development of resident specific plans of care, monitoring and evaluation of the effectiveness of the plans in place to manage responsive behaviours.
5. The development and implementation of a training program that includes an explanation of the concept of responsive behaviours, the various types of responsive behaviours that residents may demonstrate and the protocol staff must follow when a resident demonstrates a responsive behaviour.
6. The development and implementation of a system to monitor that staff consistently follow the protocol developed to assess, care plan, monitor and evaluate the effectiveness of care being provided to manage responsive behaviours.
The plan is to be submitted to Phyllis Hiltz-Bontje by email at Phyllis.Hiltzbontje@Ontario.ca on or before March 30, 2015

Grounds / Motifs :

1. In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff who did not ensure a therapy identified as required on a continuous basis by resident #001 remained functioning during and following a power outage. This inaction jeopardized the health of the resident.
-Resident #001 was admitted to the home in July 2014 and required the use of a therapy machine that required electrical power, on a continuous 24 hour bases in order to manage two identified medical conditions.
-On an identified date the resident was transferred to hospital due to a

deterioration in the resident's condition. Assessments conducted in hospital identified that the resident also suffered from another co-related medical condition and hospital physicians ordered the resident to receive a second identified therapy that required electrical power, during specific times in every 24 hour period in order to manage this condition.
-The resident returned to the home nine days later with directions for the use of this new therapy and the following day a contracted care provider executed the set-up of the equipment required for this therapy.
-Two months following the last hospital admission staff were having difficulty stabilizing the resident's condition and both the Respiratory Technician (RT) and the resident's physician determined that the resident required the use of both therapies on a continuous 24 hour basis.
-Approximately two months later the home experienced an electrical power failure that required staff to connect two extension cords from the resident's room down the hall to a generator supplied power outlet and then connect the resident's therapy equipment in order to ensure the therapy equipment continued to operate Staff were called to the resident's room three hours after the brief power failure where the Registered Nurse (RN) who responded found the resident with vital signs absent. This RN confirmed both in writing and verbally that when the electrical power source was checked the resident's therapy machine was not connected to an active power source and the machine was not functioning.
The licensee did not ensure that staff took action to ensure the respiratory therapy equipment that the resident required on a continuous basis maintained operational status during and following an electrical power outage and this inaction jeopardized the resident's health and well-being.

2. In accordance with the definition of neglect identified in O. Reg. s. 5, a pattern of inaction by staff in the assessment and management of responsive behaviours being demonstrated by resident #001 related to the use therapy equipment the resident required on a continuous 24 hour bases jeopardized the health of the resident.
- During a hospital admission for assessment of worsening condition in August 2014, it was determined that the resident had an untreated condition which was identified as a contributing factor to resident #001's worsening condition. The resident was treated in hospital with a specific therapy machine to manage this newly identified condition. Directions included in the discharge note and received by the home when the resident was discharged from the hospital indicated the

resident was to use the identified therapy machine during specific times over each 24 hour period.
-Resident #001 began demonstrating responsive behaviours related to the use of the identified therapy machine when 12 days after returned from hospital the resident disclosed to the Respiratory Technician (RT) that the therapy machine not been used since it was set up 11 days previously. The following day the RT documented that the resident indicated staff do not respond to calls on the nurse call system, the resident was fearful that if the therapy machine was removed there would not be a staff person to connect the primary therapy machine that the resident required on a continuous 24 hour basis and the resident was fearful of passing out as a result. Clinical documentation confirmed the therapy machine ordered to be used by the resident during specific times over each 24 hour period had not been used as ordered eight times during this 11 day period and for three of the 11 days there was no documentation to indicate if the therapy machine had been used. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the responsive behaviours or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 11 day period.
-The identified responsive behaviours continued and the resident was admitted to hospital 25 days later with worsening condition. A follow-up after discharge comment written by the hospital physician and received by the home indicated the resident's family physician was to ensure the resident was receiving therapy treatments as ordered and the hospital physician also indicated that nursing staff at the home were contacted to identify the importance of the resident receiving this therapy as it was ordered. Clinical documentation confirmed that in the 25 days between the resident's disclosure to the RT and this hospital admission the therapy machine had not been used 17 times and for eight of the 25 days there was no documentation to indicate the therapy machine had been used. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the responsive behaviours or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 25 day period.
- Twenty four days after the previous hospital admission for worsening condition, clinical documentation indicated the resident was again showing signs and symptoms of the same worsening condition . The physician was notified and directed staff to increase the concentration of the continuous therapy the resident was receiving and also requested Respiratory Services assess the

resident. Clinical documentation indicated the RT saw the resident, treated the resident with the use of the second therapy machine, along with the continuous therapy machine which improved the resident's condition, communicated to staff that the resident was to use both therapy machines continually and they would return the next day to further assess the resident. The following day the RT documented that a family member of the resident was contacted and at the time it was suggested that the resident's family member contact the Community Care Access Centre in order to purchase private care to assist the resident with the continuous use of the therapy equipment. In the preceding 20 days since the resident returned from hospital the clinical record confirmed that the therapy machine that was ordered to be used during specific times over each 24 hour period was not used for 11 of those identified times and for eight of the 20 days there was no documentation in the clinical record that would indicate the therapy was provided to the resident. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified responsive behaviours or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 20 day period.
- Twenty two days after the previous episode of worsening condition that required assessment and treatment the resident called Emergency Medical Services (EMS). Clinical notes indicated that both police and EMS workers responded to this call and the resident indicated to police and EMS that they were again experiencing signs and symptoms of same worsening condition and also expressed their concern that staff at the nursing home were doing nothing to address this issue. Clinical documentation indicated that EMS workers assessed the resident as having signs and symptoms that would indicate a worsening of the same condition and recommended the resident be transferred to hospital for further assessment and treatment. The resident was admitted to the hospital and both of the existing respiratory therapies were initiated. Admission notes written by the hospital physician and provided to the home indicated that the only thing the hospital could do during this current admission was ensure proper use of both of the therapies the resident had been ordered to receive two and a half months ago. In the 19 days since the resident returned from the last hospital admission and this hospital admission the clinical record confirmed that for 13 of those days the therapy ordered to be used during specific times over each 24 hour period was not used and for three of the 19 days there was no documentation in the clinical record that would indicate this therapy was provided to the resident. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified

responsive behaviours or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 19 day period.

- Approximately a month after the previous hospital admission resident #001 was found with vital signs absent and over the 25 days between the resident's return to the home from the previous hospital admission and the resident's death clinical records confirmed that for 13 of those days the therapy ordered to be used during specific times over each 24 hour period had not been used and for nine of the 25 days there was no documentation in the clinical record that would indicate the therapy was provided to the resident. Staff and the clinical record confirmed there had been no action taken to attempt to assess and manage the identified responsive behaviours or address the anxiety and fear the resident was experiencing related to staff's responses to calls for assistance in order to ensure the resident received the required treatment over this 25 day period.
- A pattern of inaction by staff in the assessment and management of the resident's responsive behaviours related to the use of therapy equipment and the resident's fear and anxiety related to staff not responding to calls for assistance resulted in the resident not receiving the required treatment which jeopardized the resident's health and well-being. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 22, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 13th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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