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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 24, 2017	2016_413500_0009	019595-16	Resident Quality Inspection

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

NITAL SHETH (500), JANET GROUX (606), JULIEANN HING (649), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 2016.

The following intakes were inspected concurrently during this RQI:
- Critical Incident (CI) Intakes related to staff to resident abuse: #036333-15, #013235-16, #016379-16, #004723-16, #009675-16, #019994-16, #021218-16
- Critical Incident (CI) Intakes related to resident to resident abuse #003059-16,

#015410-16, #012558-15, #035248-15
- Critical Incident (CI) Intake related to visitor to resident abuse #015865-16
- Critical Incident (CI) Intake related to elopement #035652-15
- Critical Incident (CI) Intakes related to falls #001326-15, #000307-15, #003231-15, #018859-16
- Critical Incident (CI) Intakes related to reporting certain matters to the Director #006306-14, #014184-16, and #035689-15

- Complaint Intakes related to duty to protect: #030428-15, #014061-16, #000933-14
- Complaint Intake related to personal support services #008708-15

- Follow-up order Intake related to Residents' Bill of Rights: #005609-16.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Food Service Supervisor, Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, Environmental Service Supervisor, Supervisor of Security, Pharmacist, Activation Coordinator, Social Worker (SW), Nursing Supervisor from the Nursing & Homemakers Inc.(NHI), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Agency Registered Practical Nurses (RPNs), Maintenance Technician, Activity Aides, Dietary Aides, Health Care Aides (HCAs), Agency Personal Support Workers (PSWs), House-Keepers, PT and Rehab Assistants, President of the Residents' Council, and Family Council, Residents, and Family Members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, meal service delivery, infection prevention and control practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2016_398605_0002	649

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences;
("mauvais traitement d'ordre affectif")

A review of Critical Incident (CI) revealed in 2016, the nurse heard resident #066 yelling from his/her room. The resident reported to the nurse, his/her roommate resident #068 had applied physical force to him/her and now again he/she is back to do the same. Resident #066 stated that resident #067 and #068 applied physical force to him/her. Resident #066 refused to stay in the same room with resident #068, and the resident was taken down to the common area.

Interview with resident #066 revealed he/she did not remember the above mentioned incident.

Interview with the family member of resident #066 revealed that the resident forgot about the incident when the family visited the resident. The family was quite concerned after becoming aware of the incident for the resident staying in a room with resident #068.

Interview with HCA #131 and RN #150 revealed that resident #066 reported when the nurse asked him/her, that resident #067 and #068 applied physical force to him/her. There was no visible injury but resident #066 was very scared and did not want to stay in the same room with resident #068.

Interview with the DOC confirmed the above mentioned incident, and the home immediately transferred resident #066 to a different floor. [s. 19. (1)]

2. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

Under O. Reg. 79/10, s. 5. for the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A review of the CI report revealed that resident #071 had a fall in 2015. The resident had sustained an injury. The resident was on the floor, he/she was in pain. RPN #144 found that the resident was not able to move. RPN #144 without completing a range of motion assessment directed HCAs to transfer the resident to the wheelchair. When RN #173 came to assess the resident, he/she found that the resident was screaming in the wheelchair. As per RN #173's assessment the pain level was higher, and the resident was admitted to the hospital for treatment.

A review of the progress note revealed the resident was found on the floor, with multiple injuries. RPN #144 assessed the resident for only one type of injury, called the nurse in charge and brought a wheelchair for the resident. Two staff and RPN #144 picked the resident up from the floor to the wheelchair. RPN# 144 noted the resident had a change in medical status. Staff and RPN #144 put resident slowly on to the wheelchair. RPN #144 brought the resident to the nursing station. RPN #144 treated for only one type of injury and neglected the other severe injury. Resident was in pain.

An interview with RPN #144, confirmed that it was his/her mistake that he/she did not complete a range of motion assessment for the resident because he/she paid attention to only one type of injury, and transferred the resident on to the wheelchair.

Interview with RN #173, confirmed that by the time he/she reached to see the resident, the resident was already on the wheel chair and it was very clear that he/she had sustained a severe injury. Immediately, RN #173 arranged a transfer to the hospital for the resident.

A review of the home's policy #VII-G-30.00, entitled "Falls Prevention", revised January

2015, revealed that when a fall occurs, all staff will ensure the resident is not moved prior to the completion of a preliminary assessment. The initial post fall assessment note must include the following physical assessment for injuries:
- Bleeding, bone fragment protrusion, lacerations, hematomas,
- Assessment of damage to the hip joint- i.e. extreme pain, shortened and or/abduction of externally rotated leg, inability to weight bear,
- Limited range of motion of joints, avoid moving against the resistance, stop if movement of a joint causes discomfort, palpate for tenderness on major joints and the rib cage, pain level identified i.e. guarding, facial expressions, grimacing, tension.

This policy indicated that registered staff will not move resident if there is suspicion or evidence of injury. The physician should be contacted and/or arrange for immediate transfer to the hospital.

Interview with RAI-Coordinator confirmed that RPN #144 should not have moved the resident without assessing him/her for a range of motion. As per the policy staff should not move the resident after a fall without the registered staff completing assessment. Registered staff are to complete a thorough investigation of fall incident including all contributing factors and complete electronic assessment by using the tool for the fall or fall incident report. Registered staff are required to update resident's plan of care to include the new intervention.

Interview with ADOC #159 revealed that, RPN #144 was required to complete a range of motion assessment before they moved the resident after fall.

Interview with RPN #144, RN #173, RAI-Coordinator and ADOC #159 revealed that RPN #144 neglected to assess the resident after sustaining a fall and moved the resident despite sustaining an injury.

The severity of the non-compliance and the severity of the harm was actual harm as it related to resident #071's injury.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed that there was Compliance Order (CO) #002 issued during inspection #2015_205129_0001, dated January 6, 2015, related to the Long-Term Care Homes Act, 2007, s. 19. (1). [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A complaint was received by MOHLTC in 2014, related to programming.

a.) A review of resident #063's care plan revealed that the resident was eager to attend all programs.

A review of the progress note, documented by Activity Aide #180 revealed that the resident mentioned to him/her that he/she was not welcomed by Activity Aide #178 to join an identified program on a day in 2013. The resident expressed it hurts his/her feelings, he/she was upset, felt neglected, disrespected and he/she could not sleep.

A review of the resident's attendance record for a day in 2013 revealed that the resident did not participate in the identified program in 2013.

Interview with the resident's family member revealed that the resident was not allowed to participate in the above mentioned program in 2013.

The resident was not available for an interview as he/she was discharged from the home in 2014.

Interview with Activity Aide #174, and #178 confirmed that the resident liked to participate in programs.

Interview with Activity Aide #174 revealed that on July 5, 2013, the resident met him/her and told him/her that he/she wanted to attend the identified program. Activity Aide #174 and the resident went to the activity room and asked for permission of Activity Aide #178 for the resident to attend the above mentioned program. Activity Aide #178 told the resident that he/she missed the same program on his/her own floor two days before. As per Activity Aide #174, Activity Aide #178 was upset at the resident and his/her tone of voice was loud which made the resident upset and felt unwelcomed to the program and the resident returned to his/her own floor.

Interview with Activity Aide #178, revealed that he/she only told the resident that he/she missed the same program on his/her own floor and Activity Aide #174 was upset and yelled at him/her, and took the resident to his/her own floor.

Interview with Dietary Aide #175 revealed that the resident was often coming to him/her to talk because he/she spoke the same language. The resident told the dietary aide that

Activity Aide #178 yelled at him/her and did not allow him/her to attend a program and the resident felt very upset about it and felt that he/she was not welcome.

Interview with Activation Co-coordinator revealed that the home investigated the incident and Activity Aide #174 was disciplined for his/her inappropriate behavior, however the home did not acknowledge the resident's wish to participate in the identified program and no one spoke to the resident about the incident except the Physiotherapy Assistant when the resident expressed his/her feelings.

Based on the staff interviews and record reviews, the inspector identified that the resident felt unwelcomed during this incident and was not able to participate in the specific program as per his/her choice and the home failed to treat resident #063 with respect and dignity.

b.) A review of the progress note revealed that the resident indicated to Activity Aide #174 that staff did not respect him/her. There was a sign posted on his/her door for staff to perform an identified action when they exit from the resident's room. The resident indicated that staff did not respect his/her request. The resident felt upset and was not able to sleep because he/she had to perform the identified action. He/she felt tired and unhappy about it.

Interview with Activity Aide #174 revealed that he/she helped the resident to write the sign, however the resident was still complaining about staff not performing the identified action.

Interview with the family member confirmed that the resident was complaining that staff "overlooked" his/her request. [s. 3. (1) 1.]

2. A review of the CI revealed that the home received a call from resident #064's family member indicating the resident was rough handled by HCA #181 during personal care in 2016. During an interview with the social worker the resident stated that HCA #181 asked the resident to participate in personal care. The resident expressed that he/she could not lift his/her arm to perform the task. HCA #181 completed the task. HCA #181 proceeded to wash the resident without rinsing with water and used a dry towel to wipe the resident and wrapped with a towel and taken back to his/her room and assisted with dressing.
The resident expressed HCA #181 had been rough, pulling on his/her wrist, telling

him/her "Hurry, Hurry". The resident was emotional and worried that the incident may occur again.

The inspector was unable to speak with the family member as the family member never return a call to the inspector.

The inspector could not complete interview with the resident as the resident was discharged.

A review of the resident's care plan revealed that the resident required total one person assistance for bathing. The resident had pain related to a specific health condition and staff to acknowledge the presence of pain and discomfort and listen to the resident's concerns.

A review of the progress note revealed that the Social Worker used the Rehab Assistant #183 to interpret the conversation with the resident. The resident was able to articulate the incident expressed a lot of emotions about the incident. Resident was feeling fearful and worried that the situation may reoccur.

Interview with HCA #181 revealed that the resident did not express any concern during personal care. He/she was aware that the resident has pain and did not ask the resident to perform the task by him/herself. He/she rinsed the resident before drying the body with a towel and dressing the resident.

Interview with the Social Worker confirmed the above mentioned statements from the resident. The Social Worker indicated that the resident had a language barrier and therefore, physiotherapy assistant was used as an interpreter to speak with the resident.

Interview with the Rehab Assistant revealed that the resident indicated that the PSW was very quick in providing care and was rushing. PSW did not clean the body properly and wiped with a towel. PSW did not pay any attention to the resident when he/she raised a concern of having pain. The resident mentioned that HCA #181 was rushed and pulling his/her hands and she was feeling afraid.

A review of the letter of counsel given to HCA # 181 revealed that the letter was non-disciplinary in nature and intended to clarify the expectation from the HCA in providing quality care to the resident in moving forward. It is important for HCA #181 to ensure communicating with the resident in the manner that is compassionate and respectful of

their wishes, aligning with the organization's value of respect, integrity, excellence and compassion.

Interview with the DOC revealed that the home did not identify any abuse occurred and PSW #181 was given a letter based on the resident's statement [s. 3. (1) 1.]

3. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

A review of the CI revealed that resident #065's family member reported to the home Agency RPN #184 rough handled the resident. Agency RPN #184 grabbed the resident's head, and pushed forward to comply to take his/her medication while the resident used hand to cover the mouth. The resident was not cooperative because he/she noticed that it was not his/her medication.

A review of the resident's care plan revealed that the resident uses nonverbal communication. He/she is able to communicate his/her needs by body language.

Interview with the family member revealed that usually staff have to crush all medications and provide to the family member and the family member administer the medication to the resident. The resident does not receive any medication at evening time as all mediations are given at meal times only because family member is present at meal times. When Agency RPN #184 administered a medication to the resident, the resident tried to refuse that medication because he/she thought that it was not his/her medication. The family member also confirmed that the resident had a misunderstanding about the medication, and felt the staff member should not have forced the resident to take the medication.

The inspector interview the resident with the assistance from the family member, the resident was able to explain how Agency RPN #184 forced him/her to take the medication. The resident explained that he/she used a blanket to cover the mouth, the nurse removed a blanket from the mouth, the resident covered the mouth using hand, the nurse removed his/her hand forcefully and pushed a spoon of medication in his/her mouth.

Interview with Agency RPN #184 revealed that he/she put the spoon around the

resident's mouth, the resident opened his/her mouth and took the medication. The resident did not refuse the medication.

Interview with RPN #101, and RN #128 revealed that if a resident refuses medication repeatedly then staff need to document that the resident refused the medication. The resident has a right to refuse the medication.

Interview with ADOC #159 revealed that the staff are required to document if the resident is refusing the medication and do not try to give medication forcefully. The resident has a right to refuse a medication.

Interview with the DOC revealed that the home did not find abuse, occurring in the above mentioned incident; however the Agency RPN #184 is not going to provide care to the resident in future. [s. 3. (1) 11. ii.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted:
- every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity,
- every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

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

Findings/Faits saillants :

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

Review of the CI revealed an incident related resident to resident abuse. It was observed by staff that resident #004 exhibited with socially inappropriate behaviour to resident #035's while they sat side by side at the nursing station.

Review of resident #035's plan of care revealed resident is diagnosed with an identified health condition which can impair his/her decisions.

Interviews with PSWs #101, #139, and RPN #101, and 107 revealed resident #004 had

been known to have this responsive behaviour and will attempt to exhibit it to identified residents inappropriately without their consent. They indicated that the written plan of care tells them to closely observe resident #004 to prevent him/her from approaching specific residents, and to firmly inform resident to stop when he/she exhibit this kind of responsive behaviour.

Review of resident #004's current written plan of care did not identify this responsive behaviour prior to the above mentioned incident. The written plan of care indicated that the update was made 29 days after the above mentioned incident.

Interview with ADOC #108 confirmed it is the home's practice that the written plan of care is updated immediately so staff are able to provide the care as set out for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

A review of the CI revealed that resident #065's family member reported to the home that Agency RPN #184 rough handled the resident. Agency RPN #184 grabbed the resident's head, and pushed forward to comply to take his/her medication while the resident used hand to cover the mouth. The resident was not cooperative because he/she noticed that it was not his/her medication.

A review of the care plan revealed that medication can be given to the resident's spouse to administer to the resident as per the spouse's request. Medication nurse to monitor that resident has taken medication. Medications administered in a manner that is preferred by the resident. A review of the care plan does not reveal that the evening medication was to be given at the specific time.

A review of Medication Administration Record (MAR) revealed that the resident was scheduled for an identified medication. It was signed by staff that this medication was administered on the date of the incident.

Interview with RPN #101 revealed that evening medication is given to the resident at the specific time, when the family member is present and the nurse will provide medications to that family member and the resident will take it. The nurse will monitor the resident take the medication. The MAR or the care plan did not indicate that the evening medication should be given at the specific time. The care plan should be specific enough

and provide clear directions to staff about the resident's care.

Interview with the DOC revealed that the written plan of care should give clear directions to staff about the administration of resident #065's medication at the specific time. [s. 6. (1) (c)]

3. According to CI submitted in 2016, resident #087 experienced a significant change in health status after they sustained an injury that resulted in bed rest after they returned from the hospital. Resident #087's written plan of care last reviewed on a specific day, identified the following discrepancies:

(I) Resident requires two staff to use the specific device for a specific type of care. The plan also indicated that no specific type of care was required.
(II) Resident will remain on bed rest until further information is obtained from the specialist.
The plan also directed staff to get resident up as much as possible.
(III) Resident is to receive a specific type of medication twice daily. RAI Coordinator #111 told LTC Inspector that the medication was discontinued on an identified day, but the written plan of care was not updated.

During interviews with RAI Coordinator #111 and RN #136 it was confirmed that resident #087's written care plan did not provide clear directions to staff. [s. 6. (1) (c)]

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

Review of resident #001's current written plan of care reveals he/she had two specific types of impaired skin integrity to certain areas of the body.

Review of resident #001's pain assessment on an identified day, indicated resident stated he/she had pain daily when touched due to his/her impaired skin integrity and described the pain as "sharp" and the intensity of the pain to be at times "horrible" or "excruciating". Further review of a skin assessment on an identified day indicated resident had signs of pain during the treatment and the pain score was higher during a treatment for the impaired skin integrity and recommended scheduled medication to be given thirty minutes prior to the treatment. Further documentation in the progress notes

indicated resident would at time refuse the treatment, and/or become resistive and uncooperative during the procedure. Ongoing pain assessments indicated resident's pain scores during treatment was at the higher level. It was also documented resident would scream during the treatment or refuse the treatment.

Interview with resident #001 revealed that he/she is was pain during treatments.

Interviews with PSW #142 and RPN #101 and #107 revealed resident was observed to be in pain whenever he/she was moved and during treatments of the impaired skin integrity. They indicated that staff manage the resident's pain by administering a medication 30 minutes to an hour prior to the treatment.

Interview with RPN #101 indicated resident had a physician order of an identified medication as needed to be given one hour prior to the treatment and was discontinued after return from the hospital. It was noted that this medication was effective in relieving the resident's pain during the treatments.

Review of the progress notes indicated resident #001 had been transferred to the hospital due to deterioration of his/her impaired skin integrity, and returned to the home diagnosed with a specific type of health condition. Further review of the progress notes indicated the resident returned from the hospital and physician orders indicated to give a specific type of medication every two hours as needed for pain.

Interview with RPN #101 revealed resident was assessed to be in pain during treatment and continued to receive pain medication one hour prior to the treatment. He/she stated he/she did not administer the medication when it was needed. Instead, he/she indicated that he/she would not administer the scheduled medication and would give it closer to the treatment and was effective in relieving resident #001's pain. He/she stated he/she does not know if the other nurses are also giving the above medication one hour before the treatment.

Interview with ADOC #159 revealed it is at the nurse's discretion to assess and make the judgement call as to whether the resident requires pain medication prior to the treatment and indicated that if the resident has been assessed to be having pain during the procedure, it was expected for the nurse to give the pain medication one hour prior to the treatment as indicated in their plan of care and confirmed it was likely not being done consistently.

The home was failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments were integrated and was consistent with and complement each other. [s. 6. (4) (a)]

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

On an identified day, on two different occasions, the LTCH Inspector observed resident #086 with a specific type of device applied inappropriately. This was brought to RN #145's attention who confirmed that it was not properly applied.

On another occasion on the other day, the LTCH Inspector observed resident in a wheelchair, along with a private sitter without having the device on. On inquiry private sitter told inspector that he/she had removed the resident's device to dress the resident.

A review of resident #086's written plan of care directed staff to apply the specific type of device when in the wheelchair to maintain safety. Visually check resident every hour for safety.

An interview with PSW #154 confirmed that they provided care to resident #086 and the identified device might have been loose and they did not noticed it. [s. 6. (7)]

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

During the review of an order issued by the Ministry of Health and Long-Term care to the home for not providing residents with an identified type of meal revealed the home had failed to provide resident #052 with an identified type of meal on two specific holidays as specified in his/her care plan.

A review of resident #052's written care plan revealed as "requested by POA, resident will enjoy an identified meal occasionally and on the specific holidays.

Interviews with Dietary Aids #204 and #205 revealed that resident #052 has not been offered an identified meal during the specific holidays from certain period of time. Dietary Aids #204 and #205 told inspector that they were unaware of the specific holidays and had not provided an identified meal to resident #052 during this period.

Interview with the FSS #100 confirmed resident #052 had not received identified meal during the above mentioned holidays. FSS further confirmed that resident #052 had also not received identified meals during the holidays on the other time period. [s. 6. (7)]

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

A review of resident #068's written care plan revealed that the resident had responsive behaviour, unpredictable situations and one on one staff round the clock to monitor the resident's behavior. Staff to initiate behavior charting to identify why the resident exhibited responsive behaviour.

A review of behavior monitoring record forms indicates to record the resident's behaviour every half an hour for 24 hours revealed that entries were missing for 22 days in 2016, during various times throughout the day.

Interview with HCA #187 confirmed that PSWs are required to document behavior monitoring and above mentioned missing entries should be documented. [s. 6. (9) 1.]

8. A review of resident #067's written care plan revealed that the resident has responsive behaviour and one on one staff round the clock to monitor the resident's behavior.

A review of behaviour monitoring record forms indicates to record the resident's behaviour every half an hour for 24 hours revealed that many entries were missing for four days in 2016, during various times throughout the day.

Interview with Agency PSW #186 confirmed that PSWs are required to document behavior monitoring and above mentioned missing entries should be documented. [s. 6. (9) 1.]

9. A review of resident #007's written care plan revealed that staff to monitor the resident to avoid conflict with other residents and initiate behavior charting to identify why the resident exhibited responsive behaviour.

A review of behaviour monitoring record forms indicates to record the resident's behaviour every half an hour for 24 hours revealed that many entries were missing for 25 days in 2016, during various times throughout the day.

Interview with RPN #108 confirmed that he/she completes behavior monitoring document for the resident, however many entries are missing when he/she is not working, during evening and night shifts. Staff are required to complete behavior monitoring documentation for the resident.

Interview with RPN #101, and ADOC #108 confirmed that staff should have documented the above mentioned missing entries to identify a pattern of the behavior of the resident. [s. 6. (9) 1.]

10. A review of resident #061's written care plan revealed that staff turn and reposition the resident every two hours and PSWs are to document care provided every shift.

A review of the resident's Point of Care (POC) records on an identified day revealed that there was no documentation available for the resident's turning and repositioning every two hours.

Interview with HCA #155 revealed that POC documentation set up from a specific month. Prior to that staff were not documenting it as POC documentation was not set up and there was no paper copy of the documentation available.

Interview with RPN #101 revealed that the POC documentation for the resident turning and repositioning every two hours was not set up and he/she set it up after the inspector notified it to him/her.

Interview with the RAI- Coordinator confirmed that the POC should have set up to document the resident's turning and repositioning records for every two hours. [s. 6. (9) 1.]

11. Review CI revealed staff to resident abuse. Resident was observed with no treatment to his/her impaired skin integrity.

Review of resident's current plan of care revealed staff were to provide care on a certain time intervals or as needed and direct staff to document after the care has been provided.

Review of resident #032's flow sheets revealed 233 missed documentation for the above care areas. Review of the resident's three months Treatment Administration Records

(TARs) revealed impaired skin integrity treatments were not documented for 15 days.

Interview with PSW #148, RN #116 and #149 revealed that the home's practice is to document the care provided after it has been completed and it has not been documented consistently.

Interview with ADOCs #108 and #159 confirmed it is the home's expectation to document in the flowsheets and TARs after care has been provided and staff did not. [s. 6. (9) 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,
- there is a written plan of care for each resident that sets out the planned care for the resident,
- there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident,
- the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments were integrated and was consistent with and complement each other
- the care set out in the plan of care is provided to the resident as specified in the plan
- the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy entitled, "Prevention of Abuse and Neglect of a Resident #V11-G-10.00 was complied with.

Review of CI revealed resident to resident abuse.

Review of resident #035's progress notes revealed resident #004 was witnessed by staff with socially inappropriate behaviour as both residents were sitting close to the nursing station.

Review of the home's policy entitled, "Prevention of Abuse and Neglect of a Resident #V11-G-10.00, current revision January 2015, indicates the charge nurse will check the resident's condition to assess his/her safety, emotional, and physical wellbeing.

Interview with PSW #131, #139 and RPN #101 revealed that resident #035 was removed away from resident #004 and was not assessed for his/her well being because the incident was witnessed by staff.

Interview with ADOC #108 confirmed that any resident involved in an incident as mentioned above must have an assessment done of their status by the registered staff. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Restraint Implementation Protocols policy # VII-E-10.00 is complied with.

On an identified day, on two different occasions, the LTCH Inspector observed resident #086 with a specific type of device applied inappropriately. This was brought to RN

#145's attention who confirmed that it was not properly applied.

On another occasion on the other day, the LTCH Inspector observed resident in a wheelchair, along with a private sitter without having the device on. On inquiry private sitter told inspector that he/she had removed the resident's device to dress the resident.

A review of the home's Restraint Implementation Protocols policy # VII-E-10.00 revised November 2015, indicated that the RNs and RPNs should obtain written consent at the initial restraint, annually, and when there is any change in the restraint order.

A review of resident #086's consent for restraint record in their chart revealed that consent was obtained from resident's SDM for the specific type of device. RN #145 confirmed that the consent had expired and required the SDM's consent. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy entitled, "Prevention of Abuse and Neglect of a Resident" #V11-G-10.00 and "Restraint Implementation Protocols Policy" # VII-E-10.00 is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

(i) During a tour of the first floor on July 20, 2016, at around 1630 hours a family member identified four dirty spots of blood on the floor in resident's room #137-W in front of their bed.

An observation by LTC Inspector on July 20, 2016, at around 1630 hours on the first floor revealed the following:

a) In the lounge area several areas of large dirty spots behind and under the chairs, underneath the curtains in front of base board heater and dust bunnies observed behind the chairs.
b) Dirty spots and dust accumulation noted in room #139 in the corner next to the window, behind the television where equipment were being stored.
c) Dirty spots observed on several different areas on the wall outside of the West dining room between the base board and the floor.
d) Large chips on the bottom half of both fire doors in the hallway. The top layer on the fire doors noted to be peeling, broken, and panel was raised. Dirty areas were observed on both corners of the floor on both sides of the fire door.
e) Dirty areas on the floor at the entrance of resident room # 114-E between the floor and baseboards on both sides of the door way, including an accumulation of dust and dirt.
f) Large soiled spot and dust on the floor behind a plant in the Garden room including dried leaves from the plants.
g) Rust like areas noted at the doorway of resident room #113-C between the floor and base board and an accumulation of dirt between the floor and base board.
h) Soiled areas and dust bunnies were noted behind the door in the Garden room where equipment was being stored.

The above mentioned observations were brought to the DOC and Environmental Service Supervisor (ESS) attention during a tour on July 21, 2016, at around 0940 hours. The DOC and ESS acknowledged the dirty areas and ESS stated that it is the home's expectation to ensure that the environment and fixtures are kept clean, tidy and in a good state of repair.

An interview with the ESS on July 22, 2016, revealed that it is the home's process for housekeeping staff to conduct weekly deep cleaning of Resident's rooms. A review of the document titled "Housekeeping Weekly Deep cleaning schedule for Resident rooms"

revealed that room #114 was deep cleaned on July 14, 2016, but did not identify any concerns. ESS stated that he/she was unaware that the room #114 required further cleaning.

On July 22, 2016, at around 0930 hours LTC Inspector confirmed with ESS that above mentioned areas c, f, and h were not cleaned.

(ii) During observations on July 4 and on July 7, 2016, resident #077 and #088's wheelchairs were observed to be dirty. On July 20, 2016, RPN #101 confirmed that resident #077 and #088's wheelchairs were dirty and needed cleaning. RPN advised that the cleaning is done by the night staff.

The home's Equipment Maintenance & Cleaning – Nursing & Resident Care policy #VII-H-10.30 dated January 2015 stated staff to "complete cleaning and inspection audits as assigned and forward to Director of Care".

During an interview with the DOC it was confirmed that the home had no documented records of the cleaning completed for July 2016 nor was unable to provide any documentation of wheelchairs that were cleaned in 2016. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #6: 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 failed to ensure that a resident exhibiting altered skin integrity such including a pressure ulcer received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Review of a complaint dated in 2016, reported resident #032 was observed by the resident’s private caregiver during the meal time in his/her bed with a soiled incontinent product and his/her impaired skin integrity without a treatment.

The private care giver reported to staff that resident’s incontinent product was soiled and requested resident #032 to be changed.

Review of resident #032's plan of care and physician orders revealed resident had impaired skin integrity on a specified body part and the physician order directs registered staff to change the treatment every seven days or as needed until it recovers as per the home’s protocol.

Review of the home's policy entitled "Skin and Wound Care Management Protocol #V11-G-10.80 current revision on April 2016, indicated registered staff will provide immediate treatment and interventions to reduce or relieve pain, promote healing, and prevention infection as required.

Interview with Private Duty Nurse (PDN) #066 revealed he/she arrived at the home during the meal hour and witnessed resident #032 in his/ her bed with a soiled incontinent product with fecal material and the impaired skin integrity covered in fecal material without a treatment applied.

Interview with HCA #148 revealed he/she informed RN#149 before the meal that resident #032's treatment had fallen off due to his/her being incontinent and required the treatment to be apply again.

Interview with RN #115 and #149 revealed it is the registered staff's responsibility to provide a treatment even when it is not scheduled whenever the treatment has been removed for any reason. They confirmed that neither one of them that shift.

Interview with RN #123 and ADOC #108 revealed the registered staff working on the unit are responsible to provide the treatment whenever it has been removed even when unscheduled and confirmed this was not followed. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity including a pressure ulcer receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint.

Interview with resident #063's family member revealed that he/she made a written complaint to the home by email identifying certain concerns regarding the resident's care to the administrator of the home in 2014.

A review of the clinical record revealed that the resident passed away in 2014.

A review of the complaint binder, 2014, revealed that there was no record available for the above mentioned complaint made by the family member.

Interview with the Administrator revealed that the home was not able to find investigation record, documentation and the response given by the home for the above mentioned complaint. [s. 101. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In 2014, CIS was submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to a hospital and which resulted in a significant change in the resident's health status. Registered staff #129 transferred resident #019 to hospital for injuried on the resident's body parts. A review of the progress noted revealed the resident returned to the home with injury.

A review of resident #19's Minimal Data Set (MDS) assessment revealed an identified device was applied daily.

Interview with PSW #130 and #131 revealed the resident was in a smaller size and when in the bed the staff applied the partial device only. A review of progress notes indicated the resident was restless on 5 days in 2013 and on one day in 2014 and after the incident.

A review of the policy Bed Rails, issued March 2008, revised April 2013, revealed the RN/RPN will assess resident's need for the use of bed rail and entrapment risk, document on the resident care plan the resident's need for bed rails, including the number of rails to be raised and the decision to use, remove, or change bed rails. If a bed rail of any size is used, the restraints/PASD assessment must be completed to identify the device as either restraint or PASD. Use bed rails pads to protect a restless resident from injury while in bed or promote proper body alignment, preventing a resident from placing limbs through or between rails.

Interview with RN #129, ADOC #108 and DOC indicated that as per the policy a resident has to be assessed for the need of an identified device and to be documented in the written plan of care and confirmed that this was not performed for resident #019. [s. 15. (1) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home have been forwarded to the Director immediately.

A review of CI report revealed in February 9, 2016, the human resources department at North York General received an anonymous letter in regards to alleged physical abuse from staff towards resident #015. The letter was forwarded to the director of care (acting) of the long term care home on the same day. The letter indicated that end of 2015, in the an identified room, RPN #101 pulled the hair of resident #015 and pushed the resident to the chair.

Interview with the Acting DOC revealed the resident passed away 2016. The letter was sent to Ministry of Health (MOH) a month later.

Interview with FSS #100 indicated because the incident of alleged physical abuse was reported to the home almost one month after the resident was deceased and the alleged staff did not work end of 2015, on the unit where the alleged physical abuse happened the home did not forward the written letter to MOH immediately. [s. 22. (1)]

2. A review of CI revealed in 2016, short stay resident #016 gave a letter to Activity Aide #110 explaining that in a previous month, he/she was not happy with the morning care provided by staff. The letter was written in an identified language and was submitted to MOH in 2016.

Interview with Activity Aide #110 revealed resident #016 gave him/her the letter in an identified month in 2016; staff made a copy and left it under the door of the Program Manager's office.

Interview with RPN #124 revealed the expectation is every written complaint or concern should be immediately reported to the charge nurse or the manager on call who will

further process the letter.

Interview with registered RAI Coordinator and DOC, confirmed that the written complaint that resident #016 handed to Activity Aide #110 in 2016, was not forwarded to the Director immediately but two days later. [s. 22. (1)]

3. As a part of the inspection completed for the complaint intake in 2014, a review of copies of emails forwarded to the inspector by resident #063's family member revealed that a written complaint was made to the home by email in an identified month in 2014, indicating concerns with the resident's care including communication with the family member about the hospitalization and incidents occurred in 2014.

Interview with the family member revealed that he/she made a written complaint to the home regarding the above mentioned concerns in 2014.

Interview with the Administrator revealed that the home was not able to verify that the above mentioned written complaint was forwarded to the Director.

A review of the email forwarded by the LTC Homes Triage and Assessment Officer on July 28, 2016, confirmed that the home did not forward the above mentioned written complaint to the Director. [s. 22. (1)]

WN #10: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), was reported to the Director.

Review of CI in 2016, reported alleged suspected abuse. The SDM reported to the home in 2016, that resident #008 had an injury and suspected that someone may have punched him/her in that area.

Review of the home's policy entitled "Prevention of Abuse and Neglect of a Resident" #V11-G-10.00 revised on January 2015, states "within ten days or when investigation is complete and confirmed, update the Ministry of Health and Long Term Care CIS".

Review of CI in 2016, revealed the home did not provide information about the outcome of the investigation.

Interview with ADOC #159 confirmed the home did not update the CI. [s. 23. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident and the suspicion and the information upon which it is based was immediately reported to the Director.

Review of CI dated in 2016, reported an allegation of resident physical abuse.

"Physical Abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Review of resident #008's progress notes revealed his/her SDM stated to RN #115 that resident had an injury and looked like someone had punched him/her. Further review of the progress notes indicated RN #115 and RN #116 assessed resident #008 and observed an injury.

Review of the home's policy entitled "Prevention of Abuse and Neglect of a Resident" #V11-G-10.00, current revision January 2015, indicates all employees are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC or designate charge of the home.

Review of the home's investigation revealed resident #008's SDM stated "someone must have punched him/her" and staff did not report it immediately to the Director of MOHLTC and the Executive Director/Administrator or designate charge of the home as indicated in the home’s policy.

Interview with ADOC #108 revealed it is the expectation of the home for staff to immediately report suspected abuse to the Director and this did not occur. [s. 24. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident was bathed, at a minimum, twice a week.

A review of the document the home referred to as residents #082, and #083's written care plans directed staff to bathe the residents on two identified days in a week and to report to the charge nurse when residents decline it.

A review of bathing records revealed that resident #082 was not bathed on two scheduled showers and resident #083 was not bathed once in 2016.

During an interview ADOC #108 and RAI Coordinator #111 confirmed that resident #082 and #083 were not bathed on their scheduled days or at any time thereafter. [s. 33. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures was developed and implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On three identified days in 2016, resident #077 and resident #088's wheelchairs were observed by LTC Inspector to be dirty.

Interview with RPN #101 confirmed the above mentioned wheelchairs were dirty and needed cleaning. RPN advised that the cleaning of wheelchairs is done by the night staff.

A review of the home's Equipment Maintenance & Cleaning – Nursing & Resident Care policy #VIIH-10.30 dated January 2015 stated that staff will complete the cleaning and inspection audits as assigned and forward to DOC. A review of the Equipment Cleaning Schedule indicated that resident's wheelchairs are scheduled for weekly cleaning and evening staff will leave the wheelchairs in the hallway at the end of their shift for night staff.

An interview with the DOC confirmed the home's process on cleaning of the resident's wheelchairs were not being followed and was unable to provide documentation of any cleaning completed for an identified month of 2016 or any other records of wheelchair cleaning done in 2016. [s. 87. (2) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that monthly audits were undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

A review of CI in 2015, reported that one ampule of an identified medication was discovered missing during a pharmacist's identified medication destruction.

A review of the home's identified medication count sheet record for resident #100 revealed that monthly audits were stopped on the above mentioned medication after resident had passed away.

During interviews, RPN #124 and ADOC #108 confirmed that it is the home's practice to conduct monthly audits on all controlled substances. RPN told LTC Inspector that they were aware of the missing medication and was hoping that another nurse would come forward to clear up the discrepancy and remove the identified medication off the unit.

ADOC #108 confirmed that the monthly audits were stopped and were not done. [s. 130. 3.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

A review of CI submitted in 2015, reported that an identified medication discovered on the second floor medication cart was missing one ampule during a pharmacist's medication destruction.

A review of the home's policy "Medication Management" under section 3.01 titled "Disposal of identified Medications" indicated under point one that specified medications to be disposed should be removed from the active medication supply until destruction of the medication.

During an interview RPN #124 stated that it is the home's practice that when identified medications have been discontinued or after the resident has passed away it should be removed from the active medication supply as soon as possible. RPN #124 confirmed that identified medications of resident #100 who passed away were still being stored on the unit together with other medications available for administration to residents until it was discovered.

Interview with the ADOC #108 confirmed that the specified medication should have been removed from the active medication supply and stored until destruction. [s. 136. (2) 2.]

Issued on this 6th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500), JANET GROUX (606), JULIEANN HING (649), SLAVICA VUCKO (210)
Inspection No. / No de l'inspection :	2016_413500_0009
Log No. / Registre no:	019595-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 24, 2017
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 :	Marianne Klein

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) (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 for achieving compliance with s. 19. (1). to ensure that residents are protected from abuse by anyone and are not neglected by the licensee or staff.

The plan should indicate how the home will ensure:

1. Staff are educated to recognize forms of abuse and neglect and comply with the home's policy on prevention of abuse and neglect.

2. The development and implementation of a monitoring and evaluation system to ensure all staff are in compliance with the home's policy on prevention of abuse and neglect.

3. Registered staff are educated to understand the home's Falls Prevention Policy and their responsibility to comply with the policy to maintain residents' safety.

4. The development and implementation of a monitoring and evaluation system to ensure all registered staff are in compliance with the home's Falls Prevention Policy.

5. The safety of residents from other residents who exhibit physical aggression and other potentially harmful responsive behaviours.

The plan should include the name of the person responsible for completing the task and the target completion dates for the tasks. The plan shall be submitted by February 10, 2017, via email to nital.sheth@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

Under O. Reg. 79/10, s. 5. for the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A review of the CI report revealed that resident #071 had a fall in 2015. The

resident had sustained an injury. The resident was on the floor, he/she was in pain. RPN #144 found that the resident was not able to move. RPN #144 without completing a range of motion assessment directed HCAs to transfer the resident to the wheelchair. When RN #173 came to assess the resident, he/she found that the resident was screaming in the wheelchair. As per RN #173's assessment the pain level was higher, and the resident was admitted to the hospital for treatment.

A review of the progress note revealed the resident was found on the floor, with multiple injuries. RPN #144 assessed the resident for only one type of injury, called the nurse in charge and brought a wheelchair for the resident. Two staff and RPN #144 picked the resident up from the floor to the wheelchair. RPN# 144 noted the resident had a change in medical status. Staff and RPN #144 put resident slowly on to the wheelchair. RPN #144 brought the resident to the nursing station. RPN #144 treated for only one type of injury and neglected the other severe injury. Resident was in pain.

An interview with RPN #144, confirmed that it was his/her mistake that he/she did not complete a range of motion assessment for the resident because he/she paid attention to only one type of injury, and transferred the resident on to the wheelchair.

Interview with RN #173, confirmed that by the time he/she reached to see the resident, the resident was already on the wheel chair and it was very clear that he/she had sustained a severe injury. Immediately, RN #173 arranged a transfer to the hospital for the resident.

A review of the home's policy #VII-G-30.00, entitled "Falls Prevention", revised January 2015, revealed that when a fall occurs, all staff will ensure the resident is not moved prior to the completion of a preliminary assessment. The initial post fall assessment note must include the following physical assessment for injuries:
- Bleeding, bone fragment protrusion, lacerations, hematomas,
- Assessment of damage to the hip joint- i.e. extreme pain, shortened and or/abduction of externally rotated leg, inability to weight bear,
- Limited range of motion of joints, avoid moving against the resistance, stop if movement of a joint causes discomfort, palpate for tenderness on major joints and the rib cage, pain level identified i.e. guarding, facial expressions, grimacing, tension.

This policy indicated that registered staff will not move resident if there is suspicion or evidence of injury. The physician should be contacted and/or arrange for immediate transfer to the hospital.

Interview with RAI-Coordinator confirmed that RPN #144 should not have moved the resident without assessing him/her for a range of motion. As per the policy staff should not move the resident after a fall without the registered staff completing assessment. Registered staff are to complete a thorough investigation of fall incident including all contributing factors and complete electronic assessment by using the tool for the fall or fall incident report. Registered staff are required to update resident's plan of care to include the new intervention.

Interview with ADOC #159 revealed that, RPN #144 was required to complete a range of motion assessment before they moved the resident after fall.

Interview with RPN #144, RN #173, RAI-Coordinator and ADOC #159 revealed that RPN #144 neglected to assess the resident after sustaining a fall and moved the resident despite sustaining an injury. (500)

2. The licensee has failed to protect residents from abuse by anyone.

For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; ("mauvais traitement d'ordre affectif")

A review of Critical Incident (CI) revealed in 2016, the nurse heard resident #066 yelling from his/her room. The resident reported to the nurse, his/her roommate resident #068 had applied physical force to him/her and now again he/she is back to do the same. Resident #066 stated that resident #067 and #068 applied physical force to him/her. Resident #066 refused to stay in the same room with resident #068, and the resident was taken down to the common area.

Interview with resident #066 revealed he/she did not remember the above mentioned incident.

Interview with the family member of resident #066 revealed that the resident forgot about the incident when the family visited the resident. The family was quite concerned after becoming aware of the incident for the resident staying in a room with resident #068.

Interview with HCA #131 and RN #150 revealed that resident #066 reported when the nurse asked him/her, that resident #067 and #068 applied physical force to him/her. There was no visible injury but resident #066 was very scared and did not want to stay in the same room with resident #068.

Interview with the DOC confirmed the above mentioned incident, and the home immediately transferred resident #066 to a different floor. [s. 19. (1)]

The severity of the non-compliance and the severity of the harm was actual harm as it related to resident #071's injury.

The scope of the non-compliance was isolated.

A review of the Compliance History revealed that there was Compliance Order (CO) #002 issued during inspection #2015_205129_0001, dated January 6, 2015, related to the Long-Term Care Homes Act, 2007, s. 19. (1). (500)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 14, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 24th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

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