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
Jun 8, 2015	2015_293554_0008	O-001964-15	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

SPRINGDALE COUNTRY MANOR
2698 CLIFFORD LINE R. R. #5 PETERBOROUGH ON K9J 6X6

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

KELLY BURNS (554), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 04-08 and May 11-15, 2015

During the Resident Quality Inspection, the following intakes were inspected upon concurrently, #O-000480-14, O-000982-14, O-001050-14, O-001387-14, O-001610-15, and O-001633-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Life Enrichment Coordinator, Environmental Services Manager, Nutritional Care Manager, Registered Dietitian, Maintenance Manager, Physiotherapist, Physiotherapy Assistant, Office Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Dietary Aide(s), Housekeeping Aide(s), Residents, and Families

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.

- **20 WN(s)**
- **11 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. 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. Related to Intake #O-001610-15:

The licensee failed to comply with LTCHA, 2007, s. 19 (1), by ensuring Resident #44 and Resident #45 were protected from abuse by anyone.

Under O. Reg. 79/10, s. 2 (1) 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, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of “abuse” in subsection 2 (1) of the Act, “verbal abuse” means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by another other than a resident.

The Director of Care submitted a Critical Incident Report (CIR) for an incident pertaining to staff to resident Abuse (verbal/emotional), which was said to have occurred on a specific date.

Details contained in the CIR are as follows:
- Two staff members were bathing Resident #44 in the spa room; as staff were drying the resident, Resident #44 indicated being cold and wanted a drink. Staff #132 commented to the resident that they were almost finished with care and that once done, would get a beverage for the resident; according to Staff #132, Staff #131 turned to the Resident #44 and remarked‘shut up Resident #44, just shut up'.

Interviews with staff, indicated that the verbal/emotional abuse incident on the date indicated, not only involved Resident #44, but also involved Resident #45.

The clinical health record for Resident #44 and Resident #45, were reviewed and indicated that both resident’s had a cognition impairment.

Director of Care indicated that neither Resident #44 nor Resident #45 could recall the interactions (verbal/emotional abuse) with Staff #131 when questioned by her, following the incident(s).

During an interview, with the inspector, Staff #132 indicated the following:
- Staff #132 indicated that he/she and Staff #131 began their shift by going room to room

to check on residents and to begin toileting residents. Staff #132 indicated that Staff #131 was in a foul mood at the beginning of the shift and recalls that Staff #131 went from resident room to resident room remarking this 'is F bulls---'. Staff #132 recalls that Staff #131's comment was something to do with alleged staff conflict in the home. Staff #132 indicated not making any comment to Staff #131 as to using foul language in the resident home area, despite residents being present in these areas.
- Staff #132 indicated that following the room/resident checks, they (both staff) took Resident #44 into the spa room for a bath. Staff #132 indicated that Staff #131 continued to remark this 'is F bulls---' in the presence of Resident #44; while they were drying Resident #44, Staff #131 told resident to 'shut up'(several times) and heard staff state to Resident #44 'just do what your told'. Staff #132 indicated he/she did not say anything to Staff #131 about the inappropriate comments and or behaviour, but indicated 'I gave Staff #131 the look'. Staff #132 indicated it wasn't my place to speak to Staff #131.
- Staff #132 indicated that following bathing and returning Resident #44 to resident's room, he/she and Staff #131 then went into the room of Resident #45 to provide resident with care. Staff #132 indicated that Staff #131 continued to curse 'this is f bulls---' while providing care to Resident #45 and was heard telling this resident (also) to 'shut up' several times. Staff #132 indicated not intervening or making any comments to Staff #131's as to the continued behaviour, but commented, to the inspector, 'I gave Staff #131 the look again'. Staff #132 indicated that once care was provided to Resident #45, he/she located Registered Nurse #117 and reported the incidents which had been witnessed.
- Staff #132 indicated he/she considered Staff #131's comments to Resident #44 and #45 to be abusive but did not immediately report the incidents as the priority was getting residents up as the home was short staffed, the evening of the incident.

Registered Nurse #117, who was considered to be in charge of the home, during the incident(s), indicated being notified by Staff #132 of the staff to resident verbal/emotional abuse incident(s). RN #117 indicated he/she did not approach or speak to Staff #131 as the Director of Care was coming into the home, for an unrelated reason, and would deal with the concerns at that time. RN #117 indicated he/she did not assess Resident #44 nor Resident #45 following Staff #132's reported concerns. RN #117 indicated that the reported behaviour of Staff #131 would be considered verbal/emotionally abusive and was unacceptable.

During an interview, the Director of Care indicated that she met with Staff #131 later that same shift, as to the alleged incident(s) of staff to resident verbal/emotional abuse; DOC indicated that Staff #131 denied telling Resident #44 to shut up, but had told Resident

#44 to 'shush'.

A review of the home's investigational notes, written by the DOC, indicated the following:
- Staff #131 denied telling Resident #44 to 'shut up; Staff #131 stated he/she had told Resident #44 'to shush'.
- There is no specific questioning relating to interactions between Staff #131 and Resident #45, despite a witness statement written by Staff #132 who had witnessed the incident(s) occurring.
- Staff #131 continued to work the scheduled shift on the same date the incident was said to have occurred. According to notes, written by DOC, Staff #131 was told to refrain from caring for 'those' particular residents for the remainder of the shift.

Progress notes, reviewed for the period of eight days, for both Resident #44 and Resident #45 indicated the following:
- Family of Resident #44 was not contacted regarding the incident of verbal/emotional abuse until approximately twenty-nine hours later.
- Family of Resident #45 was not contacted regarding the incident of abuse, which was said to have occurred.
- There is no documentation in the progress notes, or the home's investigation specific to the incident, to indicate that the family of Resident #44 was contacted at the conclusion of the home's investigation.

Registered Nurse #117 indicated he/she did not contact the families of Resident #44 or Resident #45, following the incident, as the Director of Care had stated that she would look after notification.

Director of Care indicated the following:
- The Family of Resident #44 was not notified of the incident of staff to resident verbal abuse until approximately twenty-nine hours later; DOC agreed that there was a delay in notification and indicated that she had forgotten to contact family.
- The family of Resident #45 was not contacted as to the incident of staff to resident verbal abuse which was reported by Staff #132; DOC indicated family was not contacted as Resident #45 was unable to recall any incident happening on the date indicated, and it was thought by herself that maybe the incident didn't happen as expressed by Staff #132.
- The family of Resident #44 was not contacted at the conclusion of the home's investigation, of the staff to resident verbal/emotional abuse, which said to have concluded approximately five days later, as per investigational notes (and as

communicated by DOC to the inspector).

The home's investigational notes, written by the Director of Care, indicated that Staff #131 continued to work his/her scheduled shift, but was told to refrain from providing care to 'those' particular residents. DOC indicated that Staff #131's scheduled shift ended at approximately seven hours later. DOC indicated that the direction for Staff #131 to continue to work the scheduled shift was given by the Administrator and a Corporate Representative.

The Director of Care indicated that the staff to resident incident(s) which were said to have occurred on a specific date, involving Staff #131, were deemed abusive and could be considered both verbal and or emotional abuse.

The Director of Care and the Administrator both indicated that it is an expectation that the home's polices are followed, specifically at it relates to zero tolerance of abuse.

The licensee failed to ensure the following:

- The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (b), by ensuring that the resident's SDM and any other person specified by the resident were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse. (as indicated by WN #19)

- The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion. (as indicated by WN #19)

- The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with. (as indicated by WN #13)

- The licensee failed to comply with O. Reg. 79/10, s. 104 (1) 2., by ensuring in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected, witnessed incident of abuse of a resident by anyone that led to the report. A description of the individuals involved in the incident, including, (i) the names of all residents involved with the incident. (as indicated in WN #20).

The licensee further failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 20 (2)(d), by ensuring at minimum, the policy to promote zero tolerance of abuse and neglect of a resident, contains an explanation of the duty under section 24 to make mandatory reports. (as indicated by WN #13)

- The licensee failed to comply with O. Reg. 79/10, s. 96, by ensuring the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, specifically contains (b) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; and (e) identifies the training requirements for all staff, including training on the relationship between power imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. (as indicated by WN #18) [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. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Related to Resident #04:

The licensee failed to comply with LTCHA, 2007, s. 6 (1), by ensuring there is a written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve; as well as clear directions to staff and others who provide care to Resident #04, specifically as it relates to oral hygiene and or dental care.

Resident #04 has cognition impairment. Resident #04 indicated wearing dentures, when interviewed on a specific date; when observed on this same date, resident was not wearing dentures. Resident indicated the dentures were in the washroom and he/she had forgotten to put them in.

A review of the plan of care (written plan, in place at time of inspection) failed to identify the planned care, goals care is intended to achieve and or clear directions specific to oral hygiene and or dental care required for Resident #04.

Personal Support Worker #123 indicated not being sure if Resident #04 had dentures and was unsure if staff assisted with oral hygiene and or denture care for this resident.

Director of Care indicated it would be an expectation that oral hygiene and dental needs of the resident are captured in the plan of care for each resident. [s. 6. (1)]

2. Related to Resident #31:

The licensee failed to comply with LTCHA, 2007, s. 6 (1)(b), by ensuring the written plan of care for each resident sets out the goals the care is intended to achieve.

Resident #31 was observed to have several scabbed areas on both arms and face. On further observation over the course of the inspection, some areas were observed to be broken and the areas around the wounds to be reddened.

Inspector #148 spoke with the resident who indicated that the wounds have been present most of his/her life. The health care record was reviewed and there was no corresponding diagnosis to explain the wounds. Inspector #148 spoke with PSW Staff #121 and RN Staff #116, who indicated that the resident's wounds are likely caused by and persist, due to the resident scratching him/herself. PSW #121 indicated that the resident is provided cream to affected areas. The most current Treatment Administration Record, indicates the resident is provided with a topical cream, twice daily. The physician order for the cream was dated in early 2015.

The plan of care for Resident #31 indicates that the skin is intact and that PSW staff are to assess the skin for any open areas or problems during care, and report same to registered nursing staff. The plan of care does not indicate the current status of the resident's skin, address the resident's behaviours associated with this skin issue or the goals of the current treatment cream provided. [s. 6. (1) (b)]

3. Related to Resident #32:

The licensee failed to comply with LTCHA, 2007, s. 6 (2), by ensuring that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #32 has had a significant decline in physical functioning, whereby increased assistance has been required for the performance of activities of daily living (ADL).

Inspector #148 observed the resident over a period of time, reviewed the resident's most recent plan of care, the resident's health care record including care flow sheets, the most recent Minimum Data Set (MDS) Assessment, a recent Physiotherapy Assessment and spoke to Personal Support Workers, Physiotherapist and Registered Nursing Staff.

It was determined that the resident currently requires total assistance with several ADLs, including eating, toileting, transferring with the use of a mechanical lift and mobility/locomotion. The resident's health status has declined, whereby the resident is no longer able to participate in these activities and is no longer able to weight bear. The current written plan of care describes limited assistance for transferring and bed mobility and that he/she will weight bear and pivot with one person physical assist. In addition, the plan of care indicates that extensive assistance is needed for toileting and eating (described as constant encouragement).

The plan of care also indicates that the resident is to wear firm, non -slip shoes, that glasses are to be worn at all times, that the resident is to be monitored every 15 minutes related to fall risk, to ensure that the resident is monitored when wandering and to use a baby alarm/monitor to hear the resident when mobile to intercept wandering or assist to toilet. It was determined that the resident's mobility is dependent on staff, that the behaviour of wandering no longer applies to the resident's daily care and to this extent the monitoring checks were discontinued. The resident also no longer weight bears or walks and is currently unable to wear shoes due to skin integrity issues. In addition, the resident no longer wears glasses on a regular basis, whereby glasses are not applied daily. The use of the baby alarm/monitor was related to wandering and falls out of bed, however, the resident no longer wanders and bed mobility is dependent on staff.

The plan of care is not based on the most recent assessments nor on the resident's needs as it relates to the several care areas described above.

4. Related to Resident #15:

The licensee failed to comply with LTCHA, 2007, s. 6 (2), by ensuring that the plan of care based on an assessment of the resident and the resident's needs and preferences, specifically skin and wound care.

On two separate dates, the inspector observed a small, swollen, red, abrasion on Resident #15's skin. Resident #15 indicated, the area was itchy and that it had been

there for a long time.

During an interview, Staff #110 indicated that during care yesterday, he/she was informed by other staff, that Resident #15 required the application of a specific lotion to a chronic skin issue. Staff indicated that the lotion was not prescribed, and he/she was not sure if there was instructions on the plan of care to direct staff to apply this lotion.

Upon review of the Resident's health record, the inspector could not find documentation indicating Resident #15 had altered skin integrity for this specific area, or the need for application of lotion during specific care times, as had been stated by Staff #110. The most recent plan of care directed staff, under the section Personal Hygiene, "to assess skin for any open areas or problems during care and report any changes/concerns to registered nursing staff for follow up".

During an interview, Staff #100, indicated that he/she was not aware Resident #15 had a altered skin integrity issues to the indicated area, adding that no topical creams were prescribed. After assessing the area, the Staff #100 indicated that he/she would recommend the application of indicated lotion until the physician assessed the area during his/her next visit.

Staff #108 indicated that when he/she assessed the Resident #15 on a specific date, there had been no altered skin integrity issues to the said area; Staff #108 added that the resident was known to pick at that area and might have caused the small abrasion.

The Director of Care indicated that it would be expected that if personal support workers are applying specific lotion for Resident #15, on a daily basis, the plan of care should have been updated to reflect the resident's needs and preference. [s. 6. (2)]

5. Related to Resident #21:

The licensee has failed to comply with LTCHA, 2007, s. 6 (2), by ensuring that the plan of care based on an assessment of the resident and the resident's needs and preferences, specific to use of a safety device.

Resident #21 has a cognition impairment; resident was observed during two separate dates in a wheelchair with a front closure safety device applied. When asked if could remove the safety device, the resident immediately released it. The Resident #21 indicated to the inspector that he/she liked to apply the safety device especially when the

staff portered him/her in the home, as he/she feared falling out of the wheelchair.

Upon review of the Resident's health record, there was no documentation found indicating that Resident #21 preferred the safety device applied when in the wheelchair.

During an interview with PSW #122, he/she indicated that the Resident had no safety device when sitting the wheelchair, as resident was independent.

Staff #100 indicated that if Resident #21 had a safety device it would be indicated in the plan of care, and further indicated that Resident #21 would have no reason to wear a safety device. After reviewing the most current plan of care, Staff #100 indicated that there was no information on the plan of care to indicate the resident's preference regarding application of safety device when in the wheelchair or information regarding the responsive behaviour exhibited by resident's when being portered by staff. [s. 6. (2)]

6. Related to Intake #O-000982-14, for Resident #26:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care was provided to the resident as specified in the plan, specific to Falls Prevention.

Resident #26 has a history of falls and with multiple injuries; the health record indicated Resident #26 being at high risk for falls. Resident #26 has a language barrier, and has difficulty following directions, due to moderate cognition impairment.

Upon review of the Critical Incident Report (CIR), it was indicated that Resident #26 had an unwitnessed fall on a specific date, and was transferred to the hospital due to injuries sustained during the fall. A note, in the CIR, indicated that 15 minute checks were not being done at the time Resident #26 fell.

The post-fall assessment conducted by Staff #136, on a specific date, was reviewed; it indicated that Resident #26 had an unwitnessed fall on a specific date. Resident was found on the floor in the bedroom, with poor range of motion of the lower extremities; resident was complaining of discomfort to specific areas. As per this Post-fall assessment, it was indicated that at the time of the fall, the following were not in use: restraints, personal alarms, bed alarms, bed rails, and hi/low bed.

The plan of care for Resident #26, in place at the time of the fall, was provided to the

inspector by Staff #108 and indicated the following:
- assistance of two staff for toileting and for all transfers, not able to stand without physical help
- at "High Risk for falls as evidenced by fall and past injuries
- tray when in wheelchair to protect resident from injury
- staff to provide 15 minute checks for safety
- place a magnetic bed alarm on the bed to monitor resident for climbing out of bed
- place a magnetic chair alarm on the wheelchair to monitor resident for attempting to stand on own
- monitor resident for removing bed/chair alarm
- place fall mat next to bed
- half rails on both side of the bed when in bed; place call bell within reach at all times
- ensure that shoes are sturdy and durable
- be aware that resident may attempt to stand on own from chair, monitor and remind resident to sit down or remove resident from room and bring to a common area for greater staff supervision

Upon review of the Resident #26's health record, a physician order for a specific date indicated: tray on wheelchair, 15 minute safety checks, half rails when in bed. Documentation of 15 minute safety check, application of bed/chair alarm, use of fall mat was not found for the date of the incident.

During an interview with Staff #128 indicated that he/she was assigned to care for Resident #26 during the shift of the falls incident. Staff #128 indicated that the resident preferred to go to bed immediately after supper, therefore after providing care, he/she transferred the resident to bed around a specific hour, pinned the bed alarm to the resident's nightgown, hid the bed alarm apparatus under the resident's pillow, raised the half rail and then went to break. Staff #128 indicated that the resident was known to remove the bed alarm, further indicating that the bed alarm used for the resident was the same alarm that was used when the resident was in the wheelchair. The staff added that the alarm was probably not required when the resident was in the wheelchair because the resident had a tray buckled at the back of the wheelchair preventing Resident #26 from getting out of the wheelchair. Staff #128 confirmed that the resident was not checked every 15 minutes for safety, and was unable to confirm if a fall mat was used at the time of the fall on the specific date.

During an interview with Staff #135 indicated that on the shift of the incident he/she was walking in the hallway and heard someone calling for help. Staff #135 indicated that

when he/she arrived in Resident #26's room and found the resident lying on the floor between the bed and the bathroom door. Staff #135 indicated that the resident was in a nightgown, and that he/she noticed that the bed/chair alarm was attached to the back of the resident's wheelchair, added that the same bed/chair alarm was used for Resident #26 when in the bed and the wheelchair. Staff #135 further indicated that he/she had not observed the fall, but in discussion with others, it was believed that the resident might have unpinned the bed/chair alarm attached to the nightgown, as resident was known to do this, then got out of his/her wheelchair to get to the bathroom and fell.

During an interview with Staff #136 confirmed that he/she had conducted the post-fall assessment for Resident #26 on the date of the incident. Staff #136 indicated that the resident required frequent checks by the staff due to falls risk. Staff #136 indicated that he/she believed that the resident was self-transferring from the bed to the wheelchair or vice-versa when resident fell. Staff #136 could not confirm if the wheelchair tray tied at the back of the wheelchair was used that shift, or if the bed or chair alarm was in use at the time of the fall.

Director of Care indicated she could not confirm if 15 minute checks, bed/chair alarms, fall mat were in use at the time of the fall of the incident, because the home only started to monitor these strategies during a specific month last year. The DOC indicated that the care set out in the plan of care was not provided to Resident #26 as specified in the plan of care when the resident fell, sustained injury and was sent to hospital. [s. 6. (7)]

7. The licensee failed to comply with LTCHA, 2007, s. 6 (8), by ensuring that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Interviews with Nursing Staff indicated the following:

- Staff #113 and #114, both indicated that they are unable to access resident's plan of care via the home's electronic documentation system; both staff indicted that the plan of care (or written care plan) is contained within the grey binders (resident charts) at the nursing station. Both staff indicated that changes in a resident's care would be communicated to them by the registered nursing staff during shift to shift report.

- Staff #115 indicated having access to resident's plan of care by accessing Med-eCare (resident electronic record, home's software). Staff #115 was unable to access the electronic documentation record when asked to by inspector; Staff #115 indicated having

forgotten how to access the records as he/she had not looked at any resident's plan of care nor accessed the electronic records (Med-eCare) in over 3-5 months. Staff #115 indicated being aware of changes in resident's care from shift to shift report or asking his/her co-workers if he/she was unsure of a resident' care needs.

- Staff #116, who is in a charge role, indicated being unaware as to how Personal Support Workers would be able to know if a resident's care needs change and was unable to indicate if direct care staff have access to a resident's plan of care. Staff #116 was unsure if Personal Support Workers could access Med-eCare.

Director of Care and the Administrator both indicated that all direct care staff do have access to electronic resident's plan of care, indicating all care staff do have individual access (user name and password).

Administrator indicated that each manager has been assigned a number of employee's and monthly managers are to touch base with assigned staff to ensure they are able to access the computerized health records and provide additional tech support if required; Administrator commented that she herself have not checked with managers during the past several months to see if this practice is still in place and being followed.

Administrator indicated it is the expectation that all direct care staff are kept aware of the contents of the resident's plan of care and have access to it. [s. 6. (8)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a process in place and monitored ensuring that the written plan of care for each resident that sets out, the planned care for the resident, the goals the care is intended to achieve; as well as clear directions to staff and others who provide care to residents; care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; and the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #3: 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. Related to Intake #O-001633-15:

The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b) , by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is, complied with, specific to Emergency Plans.

Under, LTCHA, 2007, s. 87 (1), Every licensee of a long term care home shall ensure that there are emergency plans in place for the home that comply with regulations

including (a) measures for dealing with emergencies, (b) procedures for evacuating and relocating the residents, and evacuation of staff and others in case of an emergency.

Under, O. Reg. 79/10, s. 230 (1), this section applies to the emergency plans required under subsection 87 91) of the Act.

Under, O. Reg. 79/10, s. 230 (2) Every licensee of a long term care home shall ensure that the emergency plans for the home are in writing.

The Administrator, submitted a Critical Incident Report (CIR) relating to a fire in the home, which was said to have occurred on a specific date.

The following information was contained in the CIR or within the home's investigational notes:
- Staff #119 started a dryer without putting clothes in it and left the laundry room; Staff #119 returned to the room at approximately twenty minutes later to find a fire had started inside the dryer. Staff #119 exited the room to tell another staff member to find the Environmental Services Manager; during this time Staff #120 heard of the fire and proceeded to the laundry room. Staff #120 indicated being able to see the fire and proceeded to extinguish the fire within the access panel (below the dryer) and inside the dryer drum itself. The fire was said to be most likely be related to the lint traps not being properly cleaned.

Neither the Critical Incident Report, nor the home's investigational notes provide evidence that the fire pull stations had been activated during the fire nor evidence that Fire Department was notified of the dryer fire.

The home's policies, Emergency Preparedness Manual – When Fire Discovered (#5.0), direct that all staff are responsible for the following if a fire is discovered:
- Sound the fire alarm from the nearest pull station, inform nursing station of the exact location of the fire so all oxygen tanks are turned off in the fire zone
- Notify the fire department
- Attempt to extinguish the fire - (step 6 of the policy, indicates extinguishment must not be attempted until the alarm has been sounded and fire department is called)

Administrator indicated that the Fire Department was not notified of the fire nor did Staff #119 or Staff #120 nor any other staff activate the fire alarm; Administrator indicated that the fire department was not notified as it was felt the fire was contained and no smoke

had entered the hallways.

Administrator indicated that it was an expectation that the home's policies are followed.

There were no reported injuries to residents during the reported fire. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is, complied with, specific to Emergency Plans, to be implemented voluntarily.

WN #4: 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 comply with LTCHA, 2007, s. 15 (2) (c), by ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during this inspection:

- Walls – in specific resident rooms or washroom(s) and in main dining room, were

observed to have areas in which inspectors could see, chipped paint, gouges, cracked or extensive damage (e.g. holes in walls, exposed dry wall) to the walls.
- Wall Guards – in specific resident rooms or washroom(s) - had loose or missing wall guards
- Ceiling Tiles – in specific resident rooms or washroom(s) – visible staining or paint chipping off
- Closets – in specific resident room(s) – closet (wardrobe) were unable to be closed due to hinges or clasp needing repair or replacement
- Counter-top Vanity – in specific resident washroom(s) – laminate missing or loose (Note: these areas had porous surfaces, which poses and infection control and or cleaning issue)
- Doors and or Door Frames – in specific resident rooms or washroom(s) and in Whirlpool #3 – were chipped and had painted missing
- Baseboard Heaters – in specific resident room(s) – had visible rust and or areas where the metal edges were torn and jagged, or the units were loose (Note: jagged metal edges present a safety hazard to residents as such may cause potential injury e.g. skin tears)
- Cup Dispensers – in specific resident room(s) – visibly rusty
- Toilets – in specific resident washroom(s) – visible brownish staining around base of toilet and flooring or missing sealant at base
- Flooring – Whirlpool #3 – greyish black staining visible along the edges of the laminate flooring
- Flooring – in specific resident rooms or washroom(s) and also in areas throughout the service corridor (accessible to residents) – flooring tiles or laminate is chipped, torn or split (Note: uneven surfaces pose a trip/fall hazard for residents)
- Tub – acrylic tub surround, in one resident home area, is chipped (Note: chipped surfaces pose a cleaning and potential infection control issue)
- Carpets – staining visible throughout areas within the home. There was also areas where carpet is visibly worn.
- Chairs – home owned chairs located in resident rooms, lounges and the main dining room were noted to have areas in which the shellac finish was worn or missing, blackish staining to legs of the chair or the seating of the chairs were worn/stained.
- Miscellaneous – The over-bed table located in one (specific) resident room was observed to be rusty in areas (frame) ; Phone or Cable jacks located in two resident room(s) were missing covers, exposing coated wires; Door handle surround was loose in one specific resident room; Washroom taps were dripping despite the faucet being turned off in two resident room(s); the metal trim surrounding a trap door, on the floor, in one hallway was duct taped.

A review of the Maintenance Repair Log binder was reviewed for the period encompassing a five month time span; the review of the binder failed to provide supporting evidence that areas identified above were in need of repair and or replacement. Of the above identified deficiencies the following two bullets were identified in the maintenance repair log:
- Cracks in wall – specific resident room; this entry is dated three months earlier (Note: this resident room extensive wall damage and holes visible)
- Trap door – metal trim lifting; this entry is dated two and a half months earlier.

Maintenance Manager was interviewed and indicated that the Maintenance Repair binder was to be used by all staff to identify areas within the home needing repairs. Maintenance Manager indicated being new to the home and was identifying areas within the home needing attention, but indicated he had no formal documentation to support his review.

The following was indicated by the Maintenance Manager:
- Approval has been granted for replacement of five resident washrooms; further indicated he knows of no repair or replacement scheduled for resident rooms and or service corridor as of this time.
- Quotes have been obtained for the repair of wall damage in 11 resident rooms, but as of this time the quotes have not been approved. Maintenance Manager indicates that he was to re-submit the quotes for approval in the next quarter. (Note: extensive wall damage in three resident room(s) had not been identified as needing repairs).
- The Maintenance Manager indicated the carpet cleaning is a contracted service and that carpets had been cleaned 10 times between the five month period reviewed. Maintenance Manager indicated the home is aware that the carpets are worn in areas, and indicated hearing that the carpeting in the a specific hall is being replaced but has not yet seen this in the current years Capitals as an expenditure.
- Closet hinges needing repair was ongoing and difficult to keep up with as staff or families over-stuff the wardrobe causing the hinge to snap.

Maintenance Manager indicated on completion of the interview that it was difficult to keep up to preventative maintenance as he was only on site three days one week (and two days the other).

The Administrator, whose role is responsible to ensure that the Preventative Maintenance Program within the home is carried out indicated no awareness of many of the identified deficiencies noted above and indicated not being aware of a corrective

action plan in place for the needed repairs. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 16, by ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

During the initial tour of the home the following was observed:
- Windows located within the Hairdressing Room, Chapel, Boardroom were found to open the entire span of the window open approximately 40 cm. A Personal Support Worker indicated these rooms are resident accessible and the Chapel and Boardroom doors are left open during the day.
- Windows in two resident room(s) were found to open approximately 22 cm.

Upon further observations windows within eleven other resident room(s) were also noted to open greater than 15 centimetres.

Staff #108 indicated that there are two residents residing within the home who are at risk of elopement; upon review and or observation, both of these residents had windows within their rooms opening greater than 15cm.

Environmental Services Manager indicated that the windows within the home have not been installed during the past year.

Administrator indicated no awareness that the window openings within resident rooms and or common areas could be opened beyond the requirement; Administrator indicated that she would have the Maintenance Manager review all the windows within the home and have the deficiency resolved.

Approximately, four days later the Administrator reported that all windows within the home had been repaired and are now meeting legislative requirements. [s. 16.]

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 there is a process in place and monitored ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Related to Resident #37 and #38:

The licensee did not ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

Female residents, #37 and #38, were observed on three separate dates with long facial hair on chin, jaw line and/or upper lip. PSW Observational Flow sheets indicated that bathing for both residents was provided twice a week and that no shaving care was provided, between a one week period. Resident #37 stated that he/she would like to have the facial hair removed and indicated that it is sometimes done by the hair dresser maybe once a week.

Inspector #148 spoke with staff members related to personal care, including shaving. It was reported that shaving is provided as needed and during bathing. The staff were not able to identify a specific reason for the presence of long facial hair on Resident #37 and #38.

The Resident Council meeting minutes during two separate dates, indicated that residents have reported that shaving care has not been provided to their satisfaction. Responses from the home's management indicate that education and monitoring would be put in place to address the issue.

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 there is a process in place and monitored ensuring that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 37 (1) (a), by ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

The following observations were made:
- A pair of glasses were observed on the counter top in the washroom of two resident rooms; both pairs of eye glasses were unlabelled, these rooms are shared by two residents. Resident #12 was unable to tell the inspector if the glasses belonged to him/her. At the time of this observation there were no residents present in the second room.
- An upper denture was observed on the counter top in the washroom of a specific resident washroom, the denture was unlabelled; this is a shared resident room.

Staff #122 indicated that resident dentures and eye glasses are not always labelled and was unsure of the reason. Staff #122 indicated that he/she was unsure of how he/she would determine whose personal items, such as eye glasses or dentures, would be identified if there was more than one on the counter top or if items were lost; staff indicated he/she would bring the personal item/aide to the Registered Nursing Staff for identification and safe keeping.

2. Related to Resident #04:

On a specific date, two registered nursing staff were overheard commenting to one another that a lower denture was found by laundry staff in the soiled laundry hamper; staff indicated denture was placed into the medication room. One of the registered nursing staff indicated that the denture was not labelled, but assumed it belonged to

Resident #29.

The following day, Resident #04 came to the nursing station to report that he/she had lost lower denture. Staff #133 indicated to Resident #04 that a lower denture had been found and that it may be his/hers; Staff #133 gave the denture to Resident #04 to try to see if it fit; denture was placed in resident's mouth and conclusion was denture fit so it must belong to Resident #04.

Staff #133 indicated that the dentures should be labelled but none of the home's resident's dentures are labelled, which makes identification difficult.

Administrator indicated that glasses are not labelled as labelling was difficult due to the small surface space; Administrator indicated that pictures are taken of resident's for the electronic medication system and staff could potentially use that to identify individual resident's glasses, but the home would look at processes for labelling of the eye glasses on a go forward basis.

Administrator indicated that the home's practice hasn't been to label dentures, but indicated that following the incident, all dentures will be labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored ensuring that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled of acquiring, or in the case of new items, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Related to Resident #21:

The licensee has failed to comply with O.Reg 79/10 s. 51 (2) b, in that the home did not ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Resident #21 has moderate cognitive impairment, and is incontinent.

On two separate dates, Inspector #545 observed a lingering offensive odour near Resident #21 and in the shared bedroom.

On a specific date, during an interview with Resident #21, resident indicated to the Inspector he/she might have an infection, as there was discomfort each time he/she voided. Resident #21 indicated he/she often had incidents of incontinence, added that he/she protected the sheets on the bed with reusable pads, and/or applied a disposable pad, as well as a towel, on the cushion of the wheelchair for protection against wetness. Resident #21 indicated he/she toileted self once or twice during the day, added that his/her family purchased continence products (own preference).

A review of the most recent plan of care indicated that Resident #21 was continent with complete control and would be clean and dry with the use of a continence product. The plan of care did not identify that the resident used his/her own continence products, that he/she refused to wear a full product at night, and that he/she protected the bed using reusable pads in the bed and disposable pads and a towel on the wheelchair.

A review of the Continence Assessments was done for a period of 9 months, the review indicated that Resident #21 was incontinent, that pads were used as incontinence product and that the resident required assistance for toileting. The February 2015

assessment indicated that the onset of incontinence was gradual over the past year.

During an interview with Staff #122 indicated that Resident #21 was incontinent, and that resident used own continence products which were kept the resident's room; Staff #122 further indicated that Resident #21 insisted on laying two of resident's own bed pads on the bed to protect the mattress against wetness. Staff #122 indicated that resident often made own bed in the morning, leaving the soiled pads from the bed for staff to put in the soiled utility carts for laundry; according to staff, resident was an independent person.

Director of Care indicated that Resident #21's individualized plan of care did not reflect the increase incontinence and increase need of assistance in promoting and managing continence based on the assessments conducted over the past year. [s. 51. (2) (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 there is a process in place and monitored ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage continence, specifically bladder continence, based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with body weight changes of 5 per cent or more, over one month; 7.5% per cent or more, over three months; and 10 per cent or more, over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Related to Resident #28:

Resident #28 has variable oral intake, swallowing difficulties known to cause choking and vomiting, issues of skin integrity, complaints of discomfort and a reported cognitive decline. The resident currently feeds self and is provided a nutritional supplement.

The weight record of Resident #28 indicates that the April 2015 weight equated to a decrease in body weight of more than 5 per cent over one month and over 7.5 per cent over 3. Further to this, the May 2015 weight indicates the weight loss to be true and stable. A review of the health care record indicates that the weight change was not identified or assessed by a staff member. Inspector #148 reviewed the nutritional program, with the home's Nutritional Care Manager (NCM), as it relates to the monitoring of resident body weights. It was reported that monthly weights are completed for each resident at the start of the month, imputed into the electronic health care record (Med e-care) by RPN #108 and electronic reports are used by the home's Registered Dietitian (RD) to identify and assess weight changes. It was confirmed that the home's RD conducted weekly visits over the course of April 2015 and that the last nutritional assessment of Resident #28 was March 2015.

Inspector #148, spoke to the RPN #108 and NCM, whereby it was reported that weights for April 2015 were completed within the first week of the month, but were not imputed into the Med e-care program until late April 2015. The NCM suspects that this may have been a contributing factor to the lack of assessment for the weight loss of Resident #28. The inspector spoke with the home's Registered Dietitian (RD) who confirmed that the weight loss of the resident had not yet been assessed. Upon provision of an assessment, the RD found that regurgitation at meals has increased, impacting on caloric intake and weight stability, of which nutritional intervention is required.

2. Related to Resident #22:

Resident #22 has several health conditions; in February 2015 it was documented that

Resident #22 was above his/her ideal weight range and was reported to have excessive intake. Resident #22 has a cognitive impairment, feeds self and has no nutritional supplements being provided.

The weight record of Resident #22 indicates that the March 2015 weight equated to a decrease in body weight of more than 5% over one month and was confirmed with a re-weigh two days later. Weight loss continued, and in April 2015 the weight equated to a further decrease in body weight of more than 7.5% over 3 months.

A review of the health care record indicates that the weight change was not identified or assessed by a staff member. A progress note in February, written by the Registered Dietitian (RD) indicates that the Resident was in hospital at the time and had skipped occasional meals to prevent bowel movements. A review of the Daily Food and Fluid Intake sheets for during a three month period indicate that on average, Resident #22 ate 75 to 100% of all three daily meals, with the exception of a few days in two specific months where the Resident refused breakfast and or lunch.

Inspector #545 reviewed the nutritional program, with the home's Nutritional Care Manager (NCM), as it relates to the monitoring of resident body weights. It was reported that monthly weights are completed for each resident at the start of the month, imputed into the electronic health care record (Med e-care) by RPN #108 and electronic reports are used by the home's Registered Dietitian (RD) to identify and assess weight changes. It was confirmed that the home's RD conducted weekly visits over the course of the months of March and April 2015 and that the last nutritional assessments of this resident were on February and April 2015; no documentation identifying the Resident's significant weight loss were found.

The Director of Care indicated that she was unable to explain resident's significant weight loss and attributed significant weight loss documented on three different dates in March and April 2015 to multiple data entry errors by staff.

The Registered Dietitian indicated to the Inspector that she suspected that the change of 5 per cent of body weight over the month and a change of 7.5 per cent of body weight over three months between March and April 2015, may have been due to fluid retention. She indicated that she missed assessing the Resident #22's significant weight loss documented by PSW for the months of March and April 2015, further adding that her focus during her visit on April 16, 2015 was to provide strategies to Resident #22 on how to best resolve issues with his/her bowel pattern. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 there is a process in place and monitored ensuring that residents with body weight changes of 5 per cent or more, over one month; 7.5% per cent or more, over three months; and 10 per cent or more, over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 86 (2) (b), by ensuring there are measures in place to prevent the transmission of infections.

The following observations were made:
- during the initial tour, pair of nail clippers, containing nail fragments, was observed in the tub room, located in a specific home area. The nail clippers were unlabelled.
- during two separate dates, a pair of nail clippers were seen sitting on top of the alcohol based hand rub station tray in the Whirlpool #3 tub room; nail clippers on one date, were observed to contain nail fragments. The nail clippers were unlabelled.
- on a specific date, nail clippers were observed in a resident sink, soaking in soap suds, in a specific resident room; the clippers were unlabelled.

Staff #122 and #150 indicated that nail clippers are not labelled for individual resident use as each resident does not have their own nail clippers. Staff #150 indicated that when nail clippers are needed for daily resident bathing, staff retrieves the nail clippers from the registered nursing staff. Staff #150 indicated having no awareness of how the nail clippers are cleaned and indicated he/she does not clean the nail clippers between resident use. Staff #122 indicated that he/she throws the nail clippers following use into the bath tub and allows the nail clippers to soak in tub solution, while he/she is cleaning the tub.

Staff #116, who is in a charge role, indicated no awareness of how nail clippers are cleaned and indicated that the home only has a few pairs of nail clippers for sixty-eight residents.

The home's policy, Care and Cleaning – Use, Care and Cleaning of Equipment (#CS-18.11) directs that each resident shall be provided with their own nail clippers to eliminate the risk of cross contamination.

The Director of Care and the Administrator, who share the role of Infection Control Coordinator, indicated being aware that each of the home's resident's do not have their own set of nail clippers; both indicated no awareness as to how nail clippers are being cleaned following resident use.

The Administrator indicated that the home does not have a policy specific to cleaning of nail clippers. [s. 86. (2) (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 there is a process in place and monitored ensuring there are measures in place to prevent the transmission of infections, specifically as it relates to nail clippers, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 101 (1) in that the home did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

And with O.Reg 79/10 s. 101 (2) in that the home did not ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time

frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

During an interview with Resident #16, the resident indicated to Inspector #545 that his/her electronic device which was stored in his/her desk, went missing approximately two months ago. Resident #16 indicated that staff were informed, however the item was still missing.

During an interview with Resident #20's Power of Attorney (POA), it was indicated to Inspector #545 that the resident's gold jewellery, went missing a few months ago. The POA indicated that three staff were informed of the missing item, and one of them had let management know, however no response had been received regarding investigation, and results.

Inspector #148 approached the home's Director of Care (DOC) for the home's documented record of complaints. A black complaints binder was provided to writer. The Log was reviewed to assess if documentation existed for the above two complaints. The most recent complaint noted in the record provided was dated approximately seven months earlier from the Family Council President and response from the Administrator. No complaints were noted for the current year. No complaints were noted for either of the items indicated above.

The Complaint Procedure, Policy, dated November 2010 was reviewed. It indicated that "any complaint given to a staff member whether verbal or written shall be directed or communicated immediately to the administrator of the home", "efforts shall be made to conclude the investigation and determine an appropriate resolution within a period of 10 days", "in the event the investigation concludes that the complaint was unfounded, a letter shall be sent to the complainant outlining the findings of the investigation and the reasons the complaint is believed to be unfounded", "if a complaint investigation cannot be completed and a resolve determined within 10 business days a letter shall be sent to the complainant acknowledging that the complaint has been received, is presently being investigated and that a response is forthcoming", " at the conclusion of the investigation the complainant shall receive a letter that explains the outcome of the investigation and what actions have been taken to resolve the complaint", "investigations shall be conducted by the Administrator or appropriate designate "

During an interview with the DOC, she indicated to Inspector #148, that no complaints were received after the date indicated earlier (previous year). The DOC indicated she didn't think any complaints had come forward since that time, and she did not believe any new complaints had been brought to her attention for this current year.

Upon review of the Resident's health record, progress notes were found indicating the following:

•Missing Electronic Device: a note, dated on a specific date, indicated that the family had reported over the weekend that the Resident's electronic device was missing from his/her room, that staff had looked for it and did not found it. The family member was advised to speak to the Director or Care.

•Missing gold jewellery: a note, dated for a specific date, indicated that the family was in and was upset that the Resident's thick gold jewellery was missing. Registered nursing staff and Director of Care looked through the Lost and Found and were unable to find the missing item. The note indicates that the search would continue.

Inspector #545 spoke with several staff members regarding Resident #16's missing electronic device and Resident #20's missing gold jewellery. Staff #130 and #134, Registered Nursing Staff #100 and #116 all indicated they were aware of Resident #16's missing electronic device as it had been reported at change of shift, that the Resident's room had been searched without success. Staff members #130, #134 and #116 indicated they were not aware of Resident #20's missing gold jewellery. Staff #116, who is in a charge role, indicated that the home's expectation was for any staff member who becomes aware of a resident or family's concerns is expected to report it to Management.

During an interview, the Administrator indicated she was aware that Resident #16 had an electronic device, because the family had asked her for access to the home's WI-FI however had to inform family that this service was not presently available, further added she was not aware that the electronic device had gone missing and maybe the DOC had dealt with the complaint. When asked about Resident #20's missing gold jewellery, she indicated she was aware of family's complaint as the item was of a sentimental value. The Administrator indicated that staff had looked for the missing gold jewellery but had not found it. Administrator indicated that she was aware of the legislative requirement and added that it was as well the home's expectation to investigate, respond to the

person who made the complaint and to keep a record of each complaint.

During a subsequent interview, Inspector #545 spoke with the Director of Care, who indicated she was aware of both complaints regarding the missing electronic device and the missing gold jewellery; DOC indicated that she had not considered them as complaints, but more as concerns.

As such, the home did not ensure that the verbal complaints made to the licensee, or a staff member, concerning Resident #16's missing electronic device or Resident #20's missing gold jewellery were dealt with. As well the home did not ensure that a documented record was kept in the home that included, the nature of both verbal complaints made by the family of Resident #16 and Resident #20, the date the complaints were received; the type of action taken to resolve the complaints, including the dates of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainants and a description of the response; and any response made in turn by the complainants. [s. 101.]

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 there is a process in place and monitored to ensure that every written and or verbal complaint made to the licensee is dealt with, specifically investigation of the complaint and response provided to the complainant, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 229 (4), by ensuring that staff participate in the implementation of the infection prevention and control program.

The following observations were made during specific dates of this inspection in Resident room(s)or common areas:

- a urinal was observed sitting on the back of the toilet in a shared washroom; the urinal contained dried yellowish-brown substance. The item was not labelled. This urinal was observed on three consecutive dates.
- a brush containing hair was observed sitting on the counter top vanity in a shared washroom; the item was unlabelled.
- two bedpans, one sitting inside the other, were observed on the floor by the toilet, in a shared washroom; both items were unlabelled. The same items were observed in the same location for two consecutive days.
- a urinal and a urine collection device was observed sitting on the back of the toilet, in a shared washroom; the urinal contained a brownish substance. The items were not labelled. Both the urinal and the collection device were observed to be in the same location for three consecutive days.
- a urinal containing yellowish substance was observed hanging from a towel bar in a shared washroom; the item was unlabelled.
- a bedpan and a urine collection device were observed lying on the floor by the toilet in a shared washroom. During this same observation, two toothbrushes and a denture cup containing a used bar of soap was seen on the counter top vanity; all items indicated were unlabelled.
- two bars of soap (used) were observed on the counter top vanity in a shared washroom. There was no way to identify which resident that soap belonged too. During another observation, soiled incontinence products, towels and washcloths were observed lying on the floor in the washroom.
- two combs, a toothbrush, two tubes of toothpaste and a denture cup were all observed in a shared washroom; the name on the denture cup was illegible, all other care items were not labelled.
- a bar of soap was observed in a soap dish on the counter top vanity in a shared washroom; the soap dish was unlabelled.
- a bedpan, with two washbasins sitting on top of it were observed under the counter in a shared resident washroom; the bedpan contained a dried whitish matter. During this same observation, a urine collection device was observed on the floor by the toilet; all items were unlabelled.
- a bedpan was observed sitting on the floor behind the toilet in a shared washroom; the

item was unlabelled.
- a toothbrush was observed on the counter top vanity in a shared washroom; the item was unlabelled.
- Whirlpool #3- a hair brush containing hair, and a roll on deodorant (half used) were observed in the storage unit in this communal spa room; items were unlabelled.

Staff #150 and Staff #130 both indicated that resident care items are to be labelled for individual resident use.

Director of Care and the Administrator, both of which share the role of Infection Control Lead, indicated that care items are to be individually labelled for resident use. DOC and ADM further indicted that bedpans, urinals, urine collection devices, incontinence products and laundry items are not to be place or stored on floors.

Administrator indicated that it is an expectation that resident care items are to be individually labelled both on admission, as items are replaced and or as needed. [s. 229. (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 there is a process in place and monitored ensuring that all staff participate in the implementation of the infection control program, specifically as such relates to labelling and storage of personal care items, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. Related to Intake #O-001610-15, for Resident #44 and Resident #45:

The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse (and or neglect) of residents is complied with.

The home's policy, Zero Tolerance of Abuse and Neglect of Residents (#AM-6.9), last reviewed January 2015, indicates that, all employees area to be aware of expected behaviour and aware of the procedures when they witness, suspect or hear of a resident being abused. The policy further indicates, it is the right of each resident to live free of abuse (and or neglect) and to be treated with courtesy and respect.

The policy, Zero Tolerance of Abuse of Residents, directs the following:
- All persons (staff) who suspect resident abuse are to immediately report the suspicion and the information to the Home's Administrator or appropriate designate.
- In cases, where a staff member witnesses, suspects or hears about an incident of abuse (or neglect, the first course of action shall be to ensure the resident is taken to a safe and secure environment. Once the resident is physically safe, the staff member is to report the incident to the direct manager, Director of Care or Administrator.
- The resident is to be provided with one on one supportive measures.
- An employee alleged to have committed an abusive act shall immediately be removed from the work environment pending investigation.

A Critical Incident Report (CIR), was submitted by the Director of Care, for an incident of staff to resident verbal/emotional abuse, which was said to have occurred on a specific date. The CIR is specific to Resident #44.

The Director of Care provided the inspector with the home's investigational notes and witness statements, specific to the incident which was said to have occurred, according to these notes, the Director of Care directed Staff #131 to refrain from providing care to Resident #44 and Resident #45 for the remainder of the shift.

Interviews with Personal Support Worker, Registered Nursing Staff and the Director of Care all confirmed recall of the incident of staff to resident verbal/emotional abuse which occurred on the identified date. Staff interviewed indicated the following:
- Staff #132 indicated that he/she witnessed Staff #131 telling Resident #44 and Resident #45 to 'shut up', telling Resident #44 'just do what your told' and heard Staff #131 swearing in the presence of both Resident #44, and #45 and in the presence of other residents when entering resident rooms and care areas.
- Staff #132 indicated that following the incident between Staff #131 and Resident #44, resident was taken to resident's room; both staff then proceed to the room of Resident #45 and provided care. Staff #132 indicated the inappropriate verbal behaviour of Staff #131 continued.
- Staff #132 indicated he/she did not immediately report his/her concerns to the Registered Nurse on shift as the priority was to get all resident's up and ready for mealtime as the home was working short staffed.
- Staff #117 indicated he/she did not approach or speak to Staff #131 following the verbal report by Staff #132 as the Director of Care was coming into the home, for an unrelated reason, and would deal with the abuse concern upon her arrival to the home. Staff #117 indicated he/she did not speak to or assess Resident #44 or Resident #45 following the

expressed concern of Staff #132.
- Director of Care confirmed that Staff #131 was told to refrain from providing care to Resident #44 and #45 at some point following the incident of verbal/emotional abuse which had occurred.

The licensee's policy that promotes zero tolerance of abuse was not complied with as evidenced by:
- Resident #44 nor Resident #45 were safe-guarded from the abuse of Staff #131
- Staff #132 did not immediately report the incident(s)of verbal/emotional abuse to Staff #117
- Staff #131 was permitted to continue to work, the scheduled shift, despite direction in the licensee's policy

The Administrator indicated it is the expectation that the policies of the home are to be followed. [s. 20. (1)]

2. The licensee did not ensure that, at a minimum, the written policy to promote zero tolerance of abuse and neglect of residents, shall (d) contain an explanation of the duty under section 24 to make mandatory reports.

As identified by the home's DOC, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

Inspector #148 reviewed the policies identified above. The policies describe the homes internal process of immediately reporting incidents to the Ministry of Health and Long Term Care including the Mandatory Critical Incident System, Centralized Intake, Assessment and Triage Team and use of the after-hours pager system.

As per policy AM #6.9, "Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Home's Administrator or appropriate designate," and "Every incidence of alleged, suspected or witnessed neglect or abuse shall be immediately reported to OMNI Home Office and the Ministry of Health and Long Term Care by the home upon learning of such an incident."

Policy AM #6.7 indicates that the home shall contact the Ministry of Health immediately upon becoming aware of abuse or neglect of a resident.

The policy to promote zero tolerance of abuse and neglect of residents does not include an explanation of the duty under section 24, for any person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report that suspicion and the information upon which it is based to the Director, as defined by section 2 (1) of the Act.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Related to Resident #24:

The licensee failed to comply with O. Reg. 79/10, s. 26 (3) 5, by ensuring that the plan of care is based on, at minimum, an interdisciplinary assessment of mood and behavioural patterns, identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Resident #24 has a cognition impairment. Resident was observed during a four day period and again during a three day period, to have greasy hair, soiled trousers and visible facial hair.

Care Flow Sheets, for Resident #24, were reviewed for a period of approximately three and a half months and indicated that on most day and evenings during this period that Personal Support Workers had identified resident was resistive to care. Resident #24 had been resistive to care 115 times during the indicated time period; resistance to care

is indicated by the Personal Support Workers completing these records as a 'check mark' only; there was no indication of strategies implemented by staff or resident's response to the same.

Progress Notes reviewed for the period indicated above, detail only four incidents where Resident #24 refused or was resistive to care, despite incidents of resistance to care noted in the care flow records by Personal Support Workers.

The plan of care (written care plan), in place at the time of this inspection, failed to provide evidence to support that Resident #24 was resistive to care, nor were there identified triggers, goals of care or strategies in place to respond to resistance to care by this resident.

The clinical health record (progress notes, assessments, written care plan, physician's assessments/notes) for Resident #24 fail to provide evidence of the resident being assessed, reassessed, and or interventions being planned or implemented to respond to Resident #24's resistance to care.

Staff #126, #127 and #128, as well as registered nursing staff #100 and #108 all indicated that Resident #24 is resistive to and refuses care. Staff #127 and #128 both indicated they know of no interventions in place for Resident #24 if care is refused. Staff indicated that if resident refuses, care is not completed nor is resident re-approached.

Staff #100 indicated the plan of care should have included strategies specific to resistance to care for this resident and further indicated that the resistance to care is not a new responsive behaviour. Staff #100 indicated that Personal Support Workers may indicate resident as having a responsive behaviour in the care flow records, but not always do staff report these incidents to registered nursing staff. Staff #100 indicated knowing of no assessments or reassessments having had being completed for Resident #24 specific to the reasoning or rationale for resident being resistive to care. Staff #100 indicated that Resident #24 has a cognitive impairment but does need care, so the plan of care should include planned strategies specific to care needs of the resident.

Director of Care and the Administrator both indicated that it is an expectation that if a resident is exhibiting a new or worsening responsive behaviour, the resident be assessed or reassessed, so that care strategies can be planned and implemented accordingly.

Administrator indicated, if a resident is known to or is exhibiting a responsive behaviour,

then such should be captured in the plan of care for that specific resident. [s. 26. (3) 5.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. Related to Resident #20:

The licensee failed to comply with O.Reg 79/10. s. 27 (1) in that the home did not ensure that, the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and a record is kept of the date, the participants, and the results of the conference

During an interview with Resident #20's family member on a specific date, it was indicated that an invitation was received, from the home, regarding attending a care conference to discuss the Resident #20's care. The family of Resident #20 indicated that due to an emergency, he/she was unable to attend, and when he/she contacted the home to inform them of such, he/she was informed that the care conference would be re-scheduled and another invitation would be sent.

Upon review of Resident #20's health record (paper and electronic chart), the inspector was unable to locate any information indicating a care conference last year was scheduled, that the substitute decision-maker (SDM) was invited to participate, the date

of the schedule or held meeting, the participants who attended and or the results of the conference.

The Director of Care (DOC) indicated that Resident #20's annual care conference was scheduled for a specific date and that a letter was sent to the resident's SDM on an identified date.

The DOC indicated that it was the home's expectation that a note be added in the resident's health record to indicate the date, participants, and the results of the annual care conference, however she had not done this for Resident #20.

Later that same day, the DOC brought a hand-written note to the Inspector, the note(s) did not state it was notes taken during the Annual Care Conference for Resident #20; it did indicate the resident's name, a date and time, names of management team in attendance (Administrator, Activities and Dietary), including point form notes indicating "medications reviewed, resident in room, may come to some activities, has a doll, refers to as baby, needs reminders, eats well, no complaints, no housekeeping/laundry concerns". The hand-written note also indicated that family was unable to attend and the care conference needed to be rescheduled. The DOC indicated that the care conference occurred at the scheduled time even though the Resident's SDM was unable to attend, and that the Resident's SDM was not invited to participate in a subsequent care conference. The notes did not indicate the results of the conference. [s. 27. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. Related to Resident #28:

The licensee did not ensure that the restraining of a resident by a physical device is included in the resident's plan of care.

Resident #28 was observed on several occasions to be seated in a wheelchair with a seat belt applied. Due to physical limitations the resident was observed to have great difficulty re-positioning self. Upon request by Inspector #148, on three occasions, the resident was not able to release the seat belt. Upon discussion with staff who provide care for the resident, it was reported that the seat belt has been in place approximately three years and that the resident's cognition has declined since this time.

The health care record including physician orders and plan of care, were reviewed. The use of the seat belt while in the wheelchair was not included in the health care record. The Inspector spoke to several staff members who reported that the use of the seat belt was to ensure the resident did not fall out of the chair and to assist with positioning the resident in the chair to prevent sliding out of the chair and injuring self.

The resident has a seat belt in use when seated in the wheelchair due to risk of injury, the restraining of Resident #28, using a physical device, is not included in the resident's plan of care.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

The licensee did not ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventative dental services.

Inspector #148 discussed the provision of annual dental service in the home with registered nursing staff and the home's DOC. It was determined that the home provides in-house professional dental service, 2-3 times a year, through an external source (Multigen). It was reported that when there are residents interested in dental services, Multigen will be called and a visit to the home will be organized. The home's DOC reported that a visit from Multigen will be organized when family and/or residents are requesting services, at this time the home does not have a process to offer dental services annually to all residents in the home.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) 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, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate and (e) identifies the 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.

As identified by the home's DOC, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

Inspector #148 reviewed the policies identified above. Policy #AM-6.9 indicates that abuse will not be tolerated in the home by staff, volunteers or any other person in the home, that the home will hold any individual who has committed abuse against a resident accountable for their actions, that any employee who neglects or abuses a resident shall be subject to disciplinary action up to and including termination of employment and/or reporting of a health professional to his or her regulatory college or association, that any employee alleged to have committed an abusive or neglectful act shall immediately be removed from the work environment pending investigation.

The home's policy to promote zero tolerance of abuse, contains procedures and interventions to deal with staff who abuses or neglects a resident or how is alleged to have abused or neglected a resident. The policies identified above do not contain procedures and interventions to deal with "persons", as appropriate, who have abused or neglected or allegedly abused or neglected residents.

In addition, policy #AM-6.9 includes a description of training to be provided to staff including the home's Respect Always program, identification of abuse and neglect and situations that may lead to abuse and neglect and avoidance of such situations and that this training will be provided on orientation and annually thereafter. The policies reviewed do not identify training on the relationship between power imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Intake #O-001610-15, for Resident #44 and Resident #45:

The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (b) , by ensuring that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Critical Incident Report (CIR), was submitted by the Director of Care, for an incident of staff to resident verbal/emotional abuse, which was said to have occurred on a specific date.

Progress notes reviewed, for a period of eight days, for both Resident #44 and #45 indicated the following:
- The family of Resident #44 were not notified of the incident of staff to resident

verbal/emotional abuse until approximately 29 hours later; notification was made by the Director of Care.
- There is no evidence, in the progress notes, to support that the Family of #45 was notified of the incident of staff to resident verbal/emotional abuse which was said to have occurred.

Staff #117, who was in charge the date of the incident, indicated that he/she did not contact the families of Resident #44 and Resident #45 as the Director of Care had indication she, herself would contact the families of the incident(s).

Director of Care indicated, during an interview, that she had forgotten to contact the family of Resident #44 and confirmed the notification was not made until approximately 29 hours later. Director of Care indicated she had not notified the family of Resident #45, as the resident was not able to recall the incident occurring.

Administrator indicated it is an expectation that families are notified of incidents involving resident's especially as such relates to incidents of alleged, suspected or witnessed abuse. [s. 97. (1) (b)]

2. Related to Intake #O-001610-15, for Resident #44:

The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

A Critical Incident Report (CIR) was submitted by the Director of Care, for an incident of staff to resident verbal/emotional abuse, which was said to have occurred on a specific date. The CIR is specific to Resident #44.

Resident #44 has a cognition impairment.

Progress notes reviewed, for a period of eight days, for Resident #44 failed to provide evidence that the family of Resident #44 was contacted as to the outcome of the home's investigation.

Director of Care indicated, during an interview, the family of Resident #44 had not been contacted as to the outcome of the staff to resident verbal/emotional abuse incident investigation, which was said to have occurred on a specific date, and ended

approximately five days later. [s. 97. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Related to Intake #O-001610-15:

The licensee failed to comply with O. Reg. 79/10, s. 104, (1) 2., by ensuring that the report to the Director included the following description of the individuals involved in the incident, (i) names of all residents involved in the incident.

The Director of Care submitted a Critical Incident Report (CIR) for an incident pertaining to staff to resident abuse (verbal/emotional), which was said to have occurred on a specific date.

The CIR specifically spoke to staff to resident abuse directed towards Resident #44, but did not include a second resident, which according to witness statements and interviews with staff and managers, the staff to resident verbal/emotional abuse also included Resident #45.

Director of Care indicated that the CIR did not include Resident #45, as the resident did not recall the incident occurring. Upon further questioning, DOC indicated Resident #44 was not interviewed, due to having advanced cognitive impairment, and commented Resident #45 also had diagnosis which included cognitive impairment. [s. 104. (1) 2.]

Issued on this 12th day of June, 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) :	KELLY BURNS (554), AMANDA NIXON (148), ANGELE ALBERT-RITCHIE (545)
Inspection No. / No de l'inspection :	2015_293554_0008
Log No. / Registre no:	O-001964-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 8, 2015
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	SPRINGDALE COUNTRY MANOR 2698 CLIFFORD LINE, R. R. #5, PETERBOROUGH, ON, K9J-6X6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MAUREEN IMAMOVIC

To OMNI HEALTH CARE LIMITED PARTNERSHIP, 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 will prepare, implement and submit a corrective action plan to ensure that residents are protected from verbal and emotional abuse by anyone.

All staff are to complete a mandatory, comprehensive and interactive education session offered in various formats to meet the learning needs of adult learners specific to, Zero Tolerance of Abuse. The education should include, but not limited to:
- definitions of abuse as defined by the regulation(s), with a heightened emphasis of the definition of verbal and emotional abuse
- explanation of 'duty to report' as it relates to LTCHA, 2007, s. 24 and the requirements relating to making mandatory reports
- the use of the MOHLTC Abuse Decision Tree Algorithms (as a guide)
- the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in positions of trust, power and responsibility for care, and situations that may lead to abuse and or neglect and how to avoid such situations
- person(s) who are to be notified in incidences of alleged, suspected or witnessed incidents of abuse
- taking appropriate actions to safe-guard residents in incidence(s) of alleged, suspected or witnessed abuse
- a review of the home's specific policies relating to: Prevention of Abuse, Mandatory Reporting, Whistle Blowing Protection and the Resident's Bill of Rights

The licensee is to ensure there is a process in place to monitor the effectiveness of the education and a process to ensure sustained compliance relating to reporting requirements specific to LTCHA, 2007, s. 24; notification of required

individuals in incidence of alleged, suspected or witnessed abuse, specifically verbal and or emotional abuse; and the need to ensure appropriate interventions are taken to safe-guard residents.

The licensee will review the corporate and any or all home specific policies which relate to zero tolerance of abuse and or neglect of residents, and will ensure that the policy or policies relating to the same are meeting with legislative requirements. The licensee will ensure that the revised policy, relating to zero tolerance of abuse and or neglect of residents is communicated to staff, residents, families or any other applicable person.

The licensee will provide a written plan on or before June 17, 2015; the plan must be submitted in writing and forwarded to the Attention of: LTC Homes Inspector, Nursing - Kelly Burns, at the following email: kelly.burns@ontario.ca

Grounds / Motifs :

1. Related to Intake #O-001610-15:

The licensee failed to comply with LTCHA, 2007, s. 19 (1), by ensuring Resident #44 and Resident #45 were protected from abuse by anyone.

Under O. Reg. 79/10, s. 2 (1) 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, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by another other than a resident.

The Director of Care submitted a Critical Incident Report (CIR) for an incident pertaining to staff to resident Abuse (verbal/emotional), which was said to have occurred on a specific date.

Details contained in the CIR are as follows:

- Two staff members were bathing Resident #44 in the spa room; as staff were drying the resident, Resident #44 indicated being cold and wanted a drink. Staff #132 commented to the resident that they were almost finished with care and that once done, would get a beverage for the resident; according to Staff #132, Staff #131 turned to the Resident #44 and remarked'shut up Resident #44, just shut up'.

Interviews with staff, indicated that the verbal/emotional abuse incident on the date indicated, not only involved Resident #44, but also involved Resident #45.

The clinical health record for Resident #44 and Resident #45, were reviewed and indicated that both resident's had a cognition impairment.

Director of Care indicated that neither Resident #44 nor Resident #45 could recall the interactions (verbal/emotional abuse) with Staff #131 when questioned by her, following the incident(s).

During an interview, with the inspector, Staff #132 indicated the following:
- Staff #132 indicated that he/she and Staff #131 began their shift by going room to room to check on residents and to begin toileting residents. Staff #132 indicated that Staff #131 was in a foul mood at the beginning of the shift and recalls that Staff #131 went from resident room to resident room remarking this 'is F bulls---'. Staff #132 recalls that Staff #131's comment was something to do with alleged staff conflict in the home. Staff #132 indicated not making any comment to Staff #131 as to using foul language in the resident home area, despite residents being present in these areas.
- Staff #132 indicated that following the room/resident checks, they (both staff) took Resident #44 into the spa room for a bath. Staff #132 indicated that Staff #131 continued to remark this 'is F bulls---' in the presence of Resident #44; while they were drying Resident #44, Staff #131 told resident to 'shut up'(several times) and heard staff state to Resident #44 'just do what your told'. Staff #132 indicated he/she did not say anything to Staff #131 about the inappropriate comments and or behaviour, but indicated 'I gave Staff #131 the look'. Staff #132 indicated it wasn't my place to speak to Staff #131.
- Staff #132 indicated that following bathing and returning Resident #44 to resident's room, he/she and Staff #131 then went into the room of Resident #45 to provide resident with care. Staff #132 indicated that Staff #131 continued to curse 'this is f bulls---' while providing care to Resident #45 and was heard telling this resident (also) to 'shut up' several times. Staff #132 indicated not

intervening or making any comments to Staff #131's as to the continued behaviour, but commented, to the inspector, 'I gave Staff #131 the look again'. Staff #132 indicated that once care was provided to Resident #45, he/she located Registered Nurse #117 and reported the incidents which had been witnessed.
- Staff #132 indicated he/she considered Staff #131's comments to Resident #44 and #45 to be abusive but did not immediately report the incidents as the priority was getting residents up as the home was short staffed, the evening of the incident.

Registered Nurse #117, who was considered to be in charge of the home, during the incident(s), indicated being notified by Staff #132 of the staff to resident verbal/emotional abuse incident(s). RN #117 indicated he/she did not approach or speak to Staff #131 as the Director of Care was coming into the home, for an unrelated reason, and would deal with the concerns at that time. RN #117 indicated he/she did not assess Resident #44 nor Resident #45 following Staff #132's reported concerns. RN #117 indicated that the reported behaviour of Staff #131 would be considered verbal/emotionally abusive and was unacceptable.

During an interview, the Director of Care indicated that she met with Staff #131 later that same shift, as to the alleged incident(s) of staff to resident verbal/emotional abuse; DOC indicated that Staff #131 denied telling Resident #44 to shut up, but had told Resident #44 to 'shush'.

A review of the home's investigational notes, written by the DOC, indicated the following:
- Staff #131 denied telling Resident #44 to 'shut up; Staff #131 stated he/she had told Resident #44 'to shush'.
- There is no specific questioning relating to interactions between Staff #131 and Resident #45, despite a witness statement written by Staff #132 who had witnessed the incident(s) occurring.
- Staff #131 continued to work the scheduled shift on the same date the incident was said to have occurred. According to notes, written by DOC, Staff #131 was told to refrain from caring for 'those' particular residents for the remainder of the shift.

Progress notes, reviewed for the period of eight days, for both Resident #44 and Resident #45 indicated the following:

- Family of Resident #44 was not contacted regarding the incident of verbal/emotional abuse until approximately twenty-nine hours later.
- Family of Resident #45 was not contacted regarding the incident of abuse, which was said to have occurred.
- There is no documentation in the progress notes, or the home's investigation specific to the incident, to indicate that the family of Resident #44 was contacted at the conclusion of the home's investigation.

Registered Nurse #117 indicated he/she did not contact the families of Resident #44 or Resident #45, following the incident, as the Director of Care had stated that she would look after notification.

Director of Care indicated the following:
- The Family of Resident #44 was not notified of the incident of staff to resident verbal abuse until approximately twenty-nine hours later; DOC agreed that there was a delay in notification and indicated that she had forgotten to contact family.

- The family of Resident #45 was not contacted as to the incident of staff to resident verbal abuse which was reported by Staff #132; DOC indicated family was not contacted as Resident #45 was unable to recall any incident happening on the date indicated, and it was thought by herself that maybe the incident didn't happen as expressed by Staff #132.
- The family of Resident #44 was not contacted at the conclusion of the home's investigation, of the staff to resident verbal/emotional abuse, which said to have concluded approximately five days later, as per investigational notes (and as communicated by DOC to the inspector).

The home's investigational notes, written by the Director of Care, indicated that Staff #131 continued to work his/her scheduled shift, but was told to refrain from providing care to 'those' particular residents. DOC indicated that Staff #131's scheduled shift ended at approximately seven hours later. DOC indicated that the direction for Staff #131 to continue to work the scheduled shift was given by the Administrator and a Corporate Representative.

The Director of Care indicated that the staff to resident incident(s) which were said to have occurred on a specific date, involving Staff #131, were deemed abusive and could be considered both verbal and or emotional abuse.

The Director of Care and the Administrator both indicated that it is an

expectation that the home's polices are followed, specifically at it relates to zero tolerance of abuse.

The licensee failed to ensure the following:

- The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (b), by ensuring that the resident's SDM and any other person specified by the resident were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse. (as indicated by WN #19)

- The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion. (as indicated by WN #19)

- The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with. (as indicated by WN #13)

- The licensee failed to comply with O. Reg. 79/10, s. 104 (1) 2., by ensuring in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected, witnessed incident of abuse of a resident by anyone that led to the report. A description of the individuals involved in the incident, including, (i) the names of all residents involved with the incident. (as indicated in WN #20).

The licensee further failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 20 (2)(d), by ensuring at minimum, the policy to promote zero tolerance of abuse and neglect of a resident, contains an explanation of the duty under section 24 to make mandatory reports. (as indicated by WN #13)

- The licensee failed to comply with O. Reg. 79/10, s. 96, by ensuring the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, specifically contains (b) procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate; and (e) identifies the training requirements for all staff, including training on the relationship between power

imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. (as indicated by WN #18) [s. 19. (1)]

During this follow up Inspection, a Critical Incident Report (CIR) was inspected; the CIR details an incident of staff to resident verbal/emotional abuse in which potential harm and or risk of harm was demonstrated as, a minimum of, two residents with cognitive impairment were receipts of verbal/emotional abuse. These incidents occurred over an approximate time span of thirty minutes and involved Resident #44, Resident #45 and potentially other residents within the resident home area. Staff #132 failed to immediately report or take appropriate action to safe-guard Resident #44 and Resident #45, from abuse; Staff #132 indicated he/she did not intervene when Staff #131 was being verbally/emotionally abusive with residents, indicating his/her priority at the time was getting the residents up and ready for mealtime. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 25, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:
- Review and update the plan of care, for Resident #26 and all other residents who are at high risk for falls, to ensure planned care is individualized and meeting the needs of the resident(s).
- Implement measures and a monitoring process to ensure that the care set out in the plan of care is provided to Resident #26 and all residents related to falls prevention and management, especially those who are at high risk.
- Provide re-instruction to all registered nursing staff specific to care planning, and ensuring that the plan of care meets the needs of each resident, specifically as it relates to falls prevention and management.
- Provide re-instruction to all direct care staff as to the importance of providing care as specified in the plan of care, specifically as it relates to falls prevention and interventions to be taken to mitigate further risk of injury or harm to the resident; direct care staff are to be made aware of who they are to contact if the planned care is not effective, so that appropriate and timely action can be taken.

Grounds / Motifs :

1. Related to Intake #O-000982-14, for Resident #26:

Resident #26 has a history of falls and with multiple injuries; the health record indicated Resident #26 being at high risk for falls. Resident #26 has a language barrier, and has difficulty following directions, due to moderate cognition impairment.

Upon review of the Critical Incident Report (CIR), it was indicated that Resident #26 had an unwitnessed fall on a specific date, and was transferred to the hospital due to injuries sustained during the fall. A note, in the CIR, indicated

that 15 minute checks were not being done at the time Resident #26 fell.

The post-fall assessment conducted by Staff #136, on a specific date, was reviewed; it indicated that Resident #26 had an unwitnessed fall on a specific date. Resident was found on the floor in the bedroom, with poor range of motion of the lower extremities; resident was complaining of discomfort to specific areas. As per this Post-fall assessment, it was indicated that at the time of the fall, the following were not in use: restraints, personal alarms, bed alarms, bed rails, and hi/low bed.

The plan of care for Resident #26, in place at the time of the fall, was provided to the inspector by Staff #108 and indicated the following:
- assistance of two staff for toileting and for all transfers, not able to stand without physical help
- at "High Risk for falls as evidenced by fall and past injuries
- tray when in wheelchair to protect resident from injury
- staff to provide 15 minute checks for safety
- place a magnetic bed alarm on the bed to monitor resident for climbing out of bed
- place a magnetic chair alarm on the wheelchair to monitor resident for attempting to stand on own
- monitor resident for removing bed/chair alarm
- place fall mat next to bed
- half rails on both side of the bed when in bed; place call bell within reach at all times
- ensure that shoes are sturdy and durable
- be aware that resident may attempt to stand on own from chair, monitor and remind resident to sit down or remove resident from room and bring to a common area for greater staff supervision

Upon review of the Resident #26's health record, a physician order for a specific date indicated: tray on wheelchair, 15 minute safety checks, half rails when in bed. Documentation of 15 minute safety check, application of bed/chair alarm, use of fall mat was not found for the date of the incident.

During an interview with Staff #128 indicated that he/she was assigned to care for Resident #26 during the shift of the falls incident. Staff #128 indicated that the resident preferred to go to bed immediately after supper, therefore after providing care, he/she transferred the resident to bed around a specific hour,

pinned the bed alarm to the resident's nightgown, hid the bed alarm apparatus under the resident's pillow, raised the half rail and then went to break. Staff #128 indicated that the resident was known to remove the bed alarm, further indicating that the bed alarm used for the resident was the same alarm that was used when the resident was in the wheelchair. The staff added that the alarm was probably not required when the resident was in the wheelchair because the resident had a tray buckled at the back of the wheelchair preventing Resident #26 from getting out of the wheelchair. Staff #128 confirmed that the resident was not checked every 15 minutes for safety, and was unable to confirm if a fall mat was used at the time of the fall on the specific date.

During an interview with Staff #135 indicated that on the shift of the incident he/she was walking in the hallway and heard someone calling for help. Staff #135 indicated that when he/she arrived in Resident #26's room and found the resident lying on the floor between the bed and the bathroom door. Staff #135 indicated that the resident was in a nightgown, and that he/she noticed that the bed/chair alarm was attached to the back of the resident's wheelchair, added that the same bed/chair alarm was used for Resident #26 when in the bed and the wheelchair. Staff #135 further indicated that he/she had not observed the fall, but in discussion with others, it was believed that the resident might have unpinned the bed/chair alarm attached to the nightgown, as resident was known to do this, then got out of his/her wheelchair to get to the bathroom and fell.

During an interview with Staff #136 confirmed that he/she had conducted the post-fall assessment for Resident #26 on the date of the incident. Staff #136 indicated that the resident required frequent checks by the staff due to falls risk. Staff #136 indicated that he/she believed that the resident was self-transferring from the bed to the wheelchair or vice-versa when resident fell. Staff #136 could not confirm if the wheelchair tray tied at the back of the wheelchair was used that shift, or if the bed or chair alarm was in use at the time of the fall.

Director of Care indicated she could not confirm if 15 minute checks, bed/chair alarms, fall mat were in use at the time of the fall of the incident, because the home only started to monitor these strategies during a specific month last year. The DOC indicated that the care set out in the plan of care was not provided to Resident #26 as specified in the plan of care when the resident fell, sustained injury and was sent to hospital. [s. 6. (7)]

During this follow up Inspection, a Critical Incident Report (CIR) was inspected,

the CIR details a falls incident in which Resident #26 sustained injury and was taken to hospital; resident was admitted to hospital and underwent further interventions. Resident #26's injury, due to the fall, resulted in a significant change in resident's health condition. Following a review of the clinical health record, for the time period of the said incident, and interviews with staff and managers, it was concluded that the planned care, specific to falls prevention, was not provided to Resident #26. (545)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 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 8th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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