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
Feb 9, 2016	2015_293554_0012	O-002303-15	Follow up

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 30, July 31 and August 04, 2015

The Follow Up Inspection (Intake #013858-15) was completed concurrently with Intakes #007840-15, #010385-15, #017438-15, and #020375-15

Summary of Intakes:
1) Follow Up Intake #013858-15 - was specific to LTCHA, 2007, 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, specific to Falls Prevention and Management. This was a Compliance Order (CO #002) issued during inspection 2015_293554_0008, with a compliance date of July 03, 2015.
2) Intake #007840-15 - relates to an incident that causes injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.
3) Intake #010385-15 - relates to incidents of resident to resident sexual abuse. This intakes includes two separate incidents involving Resident #003 and Resident #004.
4) Intake #017438-15 - relates to an incident that causes injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.
5) Intake #020375-15 - relates to an incident that causes injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

There were no orders issued in this report specific to Resident #003 and Resident #004, as
a Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during a May 2015 inspection; the incidents of resident to resident sexual abuse occurred prior to the compliance due date.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Office Manager, Life Enrichment Coordinator, Housekeeping Aide, Nutritional Care Manager, On Call Maintenance Worker and Residents.

During the course of the inspection, the inspector(s) toured the home, observed resident to resident interactions, observed staff to resident interactions, reviewed clinical health records related to assigned intakes, reviewed maintenance work requisitions binder, specific staff education (relating to prevention of abuse) and reviewed policies relating to, Zero Tolerance of Abuse and Neglect, Reporting Incidents of Abuse, Managing Responsive Behaviours, Resident Falls, Critical Incident Notification and Disclosure, Physical Restraints, and Monitoring of Personal Assistive Safety Device and Restraints.

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2015_293554_0008	554

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. 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1), by not ensuring that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specific to safe-guarding of Resident #004.

Related to Intake #010385-15, for Resident #004:

Resident #004 has a cognitive impairment. Resident is dependent on nursing staff for all activities of daily living; resident is non-ambulatory and is in a wheelchair. Personal Support Workers, Registered Nursing Staff, and the Director of Care all indicated Resident #004 is unable to provide consent.

A review of Resident #004's and Resident #003's progress notes, for a period of approximately six months, provides documentation written by registered nursing staff of three separate incidents in which Resident #004 was inappropriately touching Resident #003. The interactions between the two residents were non-consensual. There was no documented harm to Resident #004 as a result of these incidents.

A review of the written plan of care, for the period reviewed, fails to provide documentation of the planned care, the goals care is intended to achieve or clear

directions to staff and others who provide direct care to Resident #004, specific to safe-guarding Resident #004 from Resident #003, despite witnessed incidents of resident to resident abuse which occurred on three separate dates.

Registered Practical Nurse #022 and the Director of Care were unable to provide documentation of interventions (or strategies) in place to protect Resident #004 from Resident #003 during the period indicated above. RPN #022 and the Director of Care both indicated the written plan of care was not updated to reflect strategies to safe-guard Resident #004 from Resident #003 until after the third incident of abuse occurred.

The Director of Care indicated that the written care plan should have been updated after the first incident, to ensure there were strategies to safe-guard Resident #004. [s. 6. (1)]

2. The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by not ensuring the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, specific to falls prevention and management.

Related to Intake #007840-15, for Resident #002:

The home's policy, Resident Falls (#CS-12.1) directs that the Director of Care shall review the post-fall assessment and consider and discuss appropriate preventative interventions with the interdisciplinary team; the policy further directs that the Director of Care shall ensure new or changed interventions or approaches are reflected in the resident's plan of care and communicated to all care staff.

Resident #002 has a cognitive impairment; resident is dependent on staff for activities of daily living, including transfers. Resident is known by nursing staff to be at "high" risk for falls.

The written plan of care for Resident #002 (last revised on a specific date) indicated the following:
- High risk for falls related to cognitive impairment and mobility impairment. Interventions included, assist resident with transfers and ambulation as required; bed placed in lowest position; bed/chair alarm clipped to resident when in bed or while seated in chair; staff to be aware that resident is able to and will unclip bed/chair alarm; and resident is to be placed on every fifteen minute (safety) checks after falls for monitoring.

According to progress notes, reviewed for a period of approximately four months, Resident #002 had thirteen falls (including two near misses), two of the falls resulted in injuries. All falls documented, indicated resident had been attempting self-transfers, and the majority documented that Resident #002 had removed personal safety alarms (and call bells) which had been clipped to him/her by staff.

On a identified date, Resident #002 was found on the floor in his/her room (resident's fourteenth fall), he/she had unclipped the personal alarm and was assessed by registered nursing staff to have sustained injuries as result of the incident. Resident #002 was complaining of discomfort. Resident #002 was later transferred to hospital for assessment and treatment.

Personal Support Workers #012, and #017, as well as Registered Nurses #011 and #016 indicated, to the inspector, that Resident #002 was constantly removing his/her personal alarms and was self-transferring despite reminders by staff to leave in place.

Personal Support Workers #012 and #017 indicated that Resident #002 was unable to remember to ring the call bell due to cognitive impairment.

The plan of care reviewed, for Resident #002, failed to provide documentation that Resident #002 was reassessed, that the plan of care was revised or that different approaches were considered, despite nursing staff being aware that Resident #002 continued to attempt self-transfer and continued to remove (unclip) personal alarms (and or call bells), which resulted in resident falling and sustaining injuries.

The Director of Care indicated, to the inspector, that alternative interventions/approaches should have been considered knowing that Resident #002 was unclipping the personal alarms and attempting self-transfers. [s. 6. (11) (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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specific to safe-guarding of residents; and to ensure that residents are being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care, specific to falls prevention and management, to be implemented voluntarily.

WN #2: 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 not 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.

The windows in the conference room (adjacent to Life Enrichment Office) were observed open, at approximately 08:15 hours, on August 04, 2015; one window opened approximately forty centimetres and the other window opened approximately fifty-three centimetres. The door to this room was open when the inspector arrived, to the long-term care home, on August 04, 2015 (at 08:15 hours); the door to the conference room was also observed to be open on July 30, 2015 (at 14:00 – 17:00 hours) and on July 31, 2015 (at 08:00 to 16:00 hours) when and while the inspector was in the long term care home.

The Maintenance Repair Binder was reviewed for a period covering approximately three months, and failed to provide documented evidence that the maintenance department was alerted to the windows opening greater than fifteen centimetres.

Personal Support Workers and Registered Nursing Staff interviewed indicated that there are two residents residing in the home who are at known risk for elopement.

The Director of Care indicated (to the inspector) that it was thought all windows in the home were repaired in May 2015 and were meeting with the legislation; DOC indicated (to the inspector) no awareness of the windows in the conference room being deficient of the requirement for the fifteen centimetre opening (legislative requirement).

An on-call Maintenance Worker was brought into fix the window openings on August 04, 2015.

Note: O. Reg. 79/10, s. 16, was issued as a Voluntary Plan of Correction (VPC) during inspection #2015_293554_0008, which took place May 2015. [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 to monitor 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 #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1) 2, by not ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as any non-consensual touching, behaviour or

remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Related to Intake #010385-15, for Resident #003 and Resident #004:

During a review of the clinical health record, for both Resident #003 and Resident #004, the following documentation was noted in the progress notes, for Resident #003:

- On an identified date, Registered Practical Nurse (RPN) #010 was in the dining room administering medications when Personal Support Worker #012 alerted RPN #010 that Resident #003 was inappropriately touching Resident #004. The interaction was said to be non-consensual.

Registered Practical Nurse #010, who is considered to be in a supervisory role (as indicated by the Director of Care), indicated, to the inspector, that Personal Support Worker #012 told him/her (RPN) that Resident #003 was observed inappropriately touching Resident #004. RPN #010 indicated that he/she did not observe the incident, and that PSW #012 had intervened and separated both residents. Registered Practical Nurse #010 indicated there was no harm to Resident #004 as a result of this incident.

Registered Practical Nurse #010 indicated he/she did not report this abuse incident to the Director (MOHLTC), as he/she believed there was no harm to Resident #004.

Registered Practical Nurse #010 and Personal Support Worker #012 indicated that Resident #004 is unable to give consent.

Registered Practical Nurse #010 indicated, to the inspector, that he/she was contacted five days after the incident, by Registered Nurse-Charge Nurse #011 who was inquiring about the resident to resident abuse incident. RPN #010 indicated "Registered Nurse #011 had told him/her (during the phone call) that he/she (RN) had heard of the incident by staff, and commented to him/her (RPN #010) that another incident involving Resident #003 touching Resident #004 had recently occurred. Registered Practical Nurse #010 indicated he/she was told by RN #011 to make a "late entry" in the progress notes detailing the incident which occurred five days earlier.

Registered Nurse #011 indicated, to the inspector, that he/she became aware of the incident of resident to resident abuse, between Resident #003 and Resident #004, which occurred (initial incident), via nursing staff during shift report on the date in which he/she

had called RPN #010. RN #011 indicated he/she had called RPN #010 to inquire as to incident as there was no documentation of the incident in either resident's health care record. RN #011 indicated he/she thinks he/she may have reported the incident to the Director of Care following the discussion with RPN #010.

Registered Nurse #011 indicated to the inspector awareness of the reporting requirements under Section 24 of the Act; Registered Nurse #011 indicated he/she did not report the resident to resident abuse to the Director, as the incident did not occur on his/her shift, indicating "it's not my responsibility to report something that did not occur on my shift".

The Director of Care indicated having no knowledge of the incident (which occurred on an identified date) involving the non-consensual touching of Resident #004 by Resident #003. Director of Care indicated that the incident of witnessed resident to resident abuse should have been reported by not only Registered Practical Nurse #010, but also by Registered Nurse #011. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place to ensure the a person (especially a registered nursing staff in a leadership position) who has reasonable grounds to suspect that "sexual abuse" or any other abuse has occurred immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (c), by not ensuring actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Related to Intake #010385-15, for Resident #003:

According to the clinical health record, Resident #003 has a cognitive impairment.

Nursing Staff (personal support workers, registered nursing staff) Director of Care, Administrator and the Physician, all indicated that Resident does have "some cognitive impairment", but "does for the most part, know the difference between right and wrong". Nursing Staff, Director of Care and the Administrator indicated Resident #003 exhibits identified responsive behaviours and that such have been escalating.

Progress notes, for resident #003, were reviewed for a period of approximately four months. The progress notes documented that resident #003 had ongoing documented incidents where he/she exhibited identified responsive behaviours which were directed towards Resident #004 and staff/volunteers.

The interventions, included in the plan of care, for times when Resident #003 was exhibiting an identified responsive behaviour included, telling the resident his/her comments were inappropriate; attempting to distract with conversations; retract and re-approach; call resident's significant other; place on every fifteen minute checks to monitor resident's behaviour; place on DOS (observational tool); determine trigger of the

responsive behaviour; and "as needed" medications.

Personal Support Workers and Registered Nursing Staff interviewed indicated that interventions planned were rarely effective; nursing staff indicated that it was often difficult to divert Resident #003's attention when he/she exhibited a responsive behaviour.

Progress notes reviewed, specific to Resident #003's responsive behaviours failed to consistently provide documentation of the interventions (actions) taken by staff and documentation of the resident's responses to the interventions.

The plan of care reviewed for the period of approximately four months, detail resident #003 exhibiting approximately sixty-six incidents of responsive behaviours; the plan of care (including physician's orders, progress notes and care plan) fail to provide documentation to support that when resident #003 was exhibiting responsive behaviours and when interventions were ineffective, that alternative strategies were developed, implemented or that a reassessment of resident's care needs had occurred nor was there documentation suggesting that the physician was contacted when non-pharmacological and or pharmacological interventions were ineffective, despite the exhibited responsive behaviours of resident #003.

The Director of Care indicated (to the inspector) that it would be an expectation that registered nursing staff not only detail a resident's exhibited responsive behaviours in the progress notes, but also indicate resident's response to interventions or actions taken by staff. Director of Care indicated that when Resident #003 was not responding to planned interventions (pharmacological and non-pharmacological), registered nursing staff should have contacted the attending physician for direction. [s. 53. (4) (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 monitoring process in place to ensure actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 110 (2), by not ensuring that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act, specifically, 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Under LTCHA, 2007, s. 31, 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.

Under LTCHA, 2007, s. 31 (3), if a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that, (b) the resident is monitored while restrained, in accordance with requirements provided for in the regulations.

The home's policy, Physical Restraints (#CS-5.3) indicates the following:
- Physical restraints include, but are not limited to any article, device or garment that interferes with the freedom of movement of the resident and that the resident is unable to remove easily.
- Lap belt (seatbelt) and lap tray (table-top) are approved in the home as a restraint;
- Bedrails may be used and shall be considered a restraint if they are full length (on the bed) and the purpose of their use is to keep the resident in their bed.
- Monitoring of a resident with an applied restraint shall be in accordance with the "Monitoring of Physical Restraints" policy and procedure.
- It is the responsibility of the registered nursing staff to adhere to the physical restraint procedures; and the responsibility of the Director of Care to monitor compliance.

The home's policy, Personal Assistive Safety Device and Restraint Monitoring (#CS-5.6) directs the following:
- A member of the Registered Nursing Staff shall reassess the need for a physical restraint every eight hours while the resident is awake, or more often according to the needs of the resident and indicate that this has been done by initialling the restraint monitoring form in the 'needs reassessed' column.
- A member of the nursing and personal care staff shall release, reposition and reapply the physical restraint for the resident's safety and comfort every hour while the resident is awake or more often according to the needs of the resident.
- All monitoring and repositioning shall be recorded on the restraint monitoring form.

Related Intake #007840-15 and #020375-15, for Resident #002:

Resident #002 has a cognitive impairment; resident is at high risk for falls.

Progress notes, reviewed indicated that on a specific date, Resident #002 had a incident, which resulted in injury; the family (substitute decision maker) of Resident #002 requested that two bed rails be used for safety when Resident #002 was in bed. An order was obtained by resident's attending physician a day after the identified incident; substitute decision maker for Resident #002 signed consent for two bed rails to be used while in bed for safety.

Progress notes, reviewed indicated that on a specified date, Resident #002 had another incident, which resulted in injury; resident was transferred to the hospital for assessment and treatment. Four days later resident returned to the long-term care home. The substitute decision maker indicated to the registered nursing staff (date returned from

hospital), that they wanted a seatbelt or table-top tray to be in place when Resident #002 was in wheelchair. Three days later, a physician's order was received for use of table-top tray while in wheelchair; consent was signed by Resident's substitute decision maker for use of the table-top tray while in wheelchair for safety.

Personal Support Workers #012, and #017, Registered Nursing Staff #011 and #016, as well as the Director of Care all indicated that the two bed rails, as well as the table-top tray on wheelchair were considered physical restraints, as Resident #002 could not physically release either devices.

A review of the clinical health record, for Resident #002, failed to provide documentation that the use of two bed rails (in place since a specific date) and the use of the table-top tray on wheelchair (in place since a specific date) were being monitored by nursing staff.

The Director of Care indicated (to the inspector) "not being able to locate any restraint monitoring forms for Resident #002 and could only conclude the monitoring of resident's restraints was not completed" for the above indicated period of time. Director of Care indicated, to the inspector, "if there is no documentation, it can only be concluded the monitoring was not being done".

The Director of Care indicated it is an expectation that all physical restraints are to be monitored as per the home's policy and procedures. [s. 110. (2) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a monitoring process in place to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act, specifically, 3. That the resident is monitored while restrained at least every hour (and documented as per the home's policy) by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 19 (1), by not ensuring residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Related to Intake #010385-15, Resident #003 and #004:

Resident #004 has a cognitive impairment. Personal Support Workers and Registered Nursing Staff indicated (to the inspector) that Resident #004 is dependent on staff for all activities of daily living; resident is non-ambulatory and is in a wheelchair. Personal Support Workers, Registered Nursing Staff and the Director of Care all indicated that Resident #004 is unable to give consent.

The Director of Care has submitted two Critical Incident Reports to the Director, relating to resident to resident abuse of Resident #004 by Resident #003. These incidents were said to have occurred on two specific dates.

During a review of the clinical health record, for both Resident #003 and Resident #004, the following documentation was noted in the progress notes, for Resident #003:

- On a specific date, Registered Practical Nurse (RPN) #010 was in the dining room administering medications when Personal Support Worker #012 alerted RPN #010 that Resident #003 was inappropriately touching Resident #004.

Registered Practical Nurse #010, who is considered to be in a supervisory role (as indicated by the Director of Care), indicated, to the inspector, that he/she was told of the incident, involving Resident #003 and Resident #004 by Personal Support Worker #012. RPN #010 indicated that he/she did not observe any interactions, between the two residents, as PSW #012 had intervened and had removed Resident #004 from the situation and had told Resident #003 that his/her actions were inappropriate.

Registered Practical Nurse #010 indicated that the inappropriate touching of Resident #004 by Resident #003 was non-consensual, as Resident #004 was unable to provide consent. RPN #010 indicated Resident #004 "did not seem distressed by the incident".

Registered Practical Nurse #010 indicated he/she had not reported the incident of resident to resident abuse to the Charge Nurse (Registered Nurse), or to any member of the management team, nor had he/she reported the witnessed abuse to the Director (MOHLTC), to the police or to the substitute decision makers of Resident #003 or Resident #004.

Registered Practical Nurse #010 indicated he/she did not report the identified incident (resident to resident abuse) as Resident #004 had not been harmed.

Registered Nurse #011 indicated, to the inspector, that he/she became aware of the incident of resident to resident abuse, between Resident #003 and Resident #004, which he/she indicated had occurred five days earlier, via nursing staff during shift report on the date of the phone call to RPN #010. RN #011 indicated he/she had called RPN #010 to inquire as to incident as there was no documentation of the incident in either resident's health care record.

Registered Nurse #011 indicated, to the inspector, being aware that alleged, suspected or witnessed abuse is reportable to the police and to the Director (MOHLTC). RN #011 indicated he/she did not contact the police or MOHLTC (Director) regarding the sexual abuse of Resident #004 by Resident #003 as the incident did not occur on his/her shift; RN #011 indicated he/she thought he/she reported incident to Director of Care.

The Director of Care indicated, to the inspector, having no knowledge of the resident to resident abuse incident, which was said to have occurred on an identified shift.

Director of Care indicated that all staff are to follow the home's policies, especially as

such relates to abuse of a resident.

The incident of resident to resident sexual abuse, which occurred on a specific date, was not reported on the date to which it had occurred, nor had the license reported the incident to the Director at the time of this inspection.

Therefore, the licensee failed to protect Resident #004 from sexual abuse by Resident #003, as identified by the following:

- Under LTCHA, 2007, s. 6 (1), every licensee shall ensure that there is a written plan of care for each resident that sets out,(a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specific to safe-guarding of Resident #004. (as indicated by Written Notification and Voluntary Plan of Correction #1)

- Under O. Reg. 79/10, s. 98 – every licensee shall ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (as indicated by Written Notification #9)

- Under O. Reg. 79/10, s. 97 (1) (b), 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, are notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse (or neglect) of a resident. (as indicated by WN #8)

- Under O. Reg. 79/10, s. 53 (4) (c), every licensee shall ensure that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (as indicated by Written Notification and Voluntary Plan of Correction #4)

- Under LTCHA, 2007 s. 20 (1), every licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (as indicated by Written Notification #7)

- Under LTCHA, 2007, s. 24 (1), a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically, abuse of a resident by

anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (as indicated by Written Notification and Voluntary Plan of Correction #3)

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during a May 2015 inspection, which included a written notification (WN) specific to LTCHA, 2007, s. 20 (1) and O. Reg. 79/10, s. 97 (1) (b); the incidents of resident to resident abuse occurred prior to the compliance due date. [s. 19. (1)]

WN #7: 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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 20 (1), by not ensuring the written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home's policy, Zero Tolerance of Abuse and Neglect of Residents (#AM-6.9) speaks to all employees being aware of procedures when they witness, suspect or hear of a resident being abused (and or neglected).

The Zero Tolerance of Abuse and Neglect of Resident's policy, directs the following the following procedures:
- Any person who has reasonable grounds to suspect that a resident has been abused is obligated to immediately report the suspicion and information to the Director (MOHLTC), Home's Administrator or manager on call;
- Each incidence of abuse shall be considered and immediately reported as a critical incident and shall be reported to the Director of Operations (OMNI), and MOHLTC by telephone and computerized submission of a Mandatory Critical Incident System form;
- In cases, where a staff member witnesses/suspects/hears about an act of abuse, the

first course of action shall be to ensure the resident is taken to as safe and secure environment. Once the resident is physically safe, the following steps shall be taken: report the incident to direct manager, Director of Care or Administrator; provide the resident with one on one supportive measures; and assess the needs (of the resident) for advanced medical assessment and treatment including psychosocial or physical interventions;
- An investigation shall be conducted in accordance with the investigation procedures policy;
- Appropriate actions shall be determined by the result of the investigation and shall include: notification and ongoing communications with the resident, family members or substitute decision maker; follow up care for the resident as deemed appropriate by medical and nursing assessment.

Related to Intake #010385-15, Resident #003 and #004:

During a review of the clinical health record, for both Resident #003 and Resident #004, the following documentation was noted in the progress notes, for Resident #003:

On a specific date, Registered Practical Nurse (RPN) #010 was in the dining room administering medications when Personal Support Worker #012 alerted RPN #010 that Resident #003 was inappropriately touching Resident #004.

Registered Practical Nurse #010, who is considered to be in a supervisory role, indicated to the inspector, that he/she was told of the incident, involving Resident #003 and Resident #004 by Personal Support Worker #012. RPN #010 indicated that he/she did not observe any interactions as PSW #012 had intervened and had separated the two residents.

Registered Practical Nurse #010 indicated that the incident involving Resident #003 and Resident #004 was non-consensual, as Resident #004 could not provide consent.

Registered Practical Nurse #010:
- despite being notified, by Personal Support Worker #012, that Resident #003 had inappropriately touched Resident #004, Registered Practical Nurse #010 did not assess Resident #004 for injuries or the need for advanced medical assessment. RPN did indicated to the inspector, that Resident #004 "was not distressed by the incident".
- did not notify the Charge Nurse of the witnessed abuse incident; nor did RPN #010 notify the Director of Care, Administrator or Operations Personnel of the abuse of

Resident #004 by Resident #003;
- did not immediately notify the Director (MOHLTC) of the witnessed abuse incident involving Resident #003 and #004 (Note: to date, this incident has not been reported to the Director).
- did not notify Resident #003 or #004's substitute decision maker of the abuse incident
- did not notify the police of the witnessed abuse of Resident #004 by Resident #003.

Registered Practical Nurse #010 indicated that he/she was not familiar with the home's policy, Zero Tolerance of Abuse and Neglect of a Resident.

Director of Care indicated that all staff have been provided education specific to the home's policies and procedures, specifically as it relates to prevention and reporting of abuse.

Director of Care indicated it is an expectation that all staff follow home related policies.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during a May 2015 inspection, which included a written notification (WN) specific to LTCHA, 2007, s. 20 (1); the incidents of resident to resident abuse occurred prior to the compliance due date. [s. 20. (1)]

WN #8: 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).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (b), by not ensuring that the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed abuse or neglect of a resident.

Related to Intake #010385-15, for Resident #003 and #004:

On a specific date, Registered Practical Nurse (RPN #010), who is in a supervisory role, was in the dining room administering medications when Personal Support Worker #012 alerted RPN #010 that Resident #003 was inappropriately touching Resident #004.

Registered Practical Nurse #010 indicated (to the inspector) he/she did not notify the substitute decision maker for Resident #004 or Resident #003, despite the witnessed incident of resident to resident abuse; Registered Practical Nurse #010 indicated there was no harm to either resident and he/she felt the incident was resolved. Registered Practical Nurse #010 indicated that thinking back to the incident, both resident families should have been notified.

Director of Care indicated (to the inspector) that the witnessed abuse incident should have been reported to the substitute decision makers for both residents.

A Compliance Order (CO #001), under LTCHA, 2007, s. 19, was issued during a May 2015 inspection, which included a written notification (WN) specific to O. Reg. 79/10, s. 97 (1) (b); the incidents of resident to resident sexual abuse occurred prior to the compliance due date indicated within this inspection. [s. 97. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 98, by not ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #010385-15, for Resident #003 and #004:

On a specific date, Registered Practical Nurse (RPN) #010 was in the dining room administering medications when Personal Support Worker #012 alerted RPN #010 that Resident #003 was inappropriately touching Resident #004.

Registered Practical Nurse #010, who works in a supervisory role, indicated (to the inspector) that he/she had not reported the resident to resident abuse incident to the police. RPN #010 indicated he/she did not realize the incident was reportable to the police; RPN #010 indicated Resident #004 was not harmed by the incident, indicating "Resident #004 was not in any distress".

Five days later, Registered Nurse #011, who is a Charge Nurse, became aware of the incident (identified above) of resident to resident abuse of Resident #004 by Resident #003; RN #011 indicated (to the inspector) he/she had contacted RPN #010 to obtain details of the abuse incident.

Registered Nurse #011 indicated (to the inspector) being aware that alleged, suspected or witnessed abuse is reportable to the police. RN #011 indicated he/she had not contact the police regarding the abuse of Resident #004 by Resident #003 as the incident did not occur on his/her shift. [s. 98.]

WN #10: 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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 104 (2), by not ensuring that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Related to Intake #010385-15, for Resident #003 and #004:

On an identified date, a staff member was walking down the hallway and witnessed Resident #003 inappropriately touching Resident #004. The two residents were immediately separated. The incident involving resident to resident abuse was reported to the management team.

The Director of Care reported the incident to C.I.A.T.T (Centralized Intake Assessment and Triage Team) the same day of the incident.

The Critical Incident Report, specific to the resident to resident witnessed abuse, was not submitted to the Director for eleven days.

The Director of Care indicated (to the inspector) being unaware of why the Critical Incident Report was late being submitted. [s. 104. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director

setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any 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. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 107 (4), by not ensuring that a report in writing was made to the Director, within 10 days of the licensee becoming aware of the incident, specific to an incident under subsection (1), (3) or (3.1).

Under subsection O. Reg. 79/19, s. 107 (3.1), the licensee shall within 10 day of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director (and include specific information).

Related to Intake #020375-15, for Resident #002:

Resident #002 was found by Personal Support Worker on a specific date, lying on the floor in resident's room. Resident #002 was assessed by a registered nurse, and a decision was made to transfer resident to hospital for further assessment. Resident was assessed and treated at the hospital; resident returned to the long-term home four days later.

C.I.A.T.T. (Centralized Intake Assessment and Triage Team) was notified by the Director of Care, of the incident and subsequent injury the day after the incident occurred.

The Director of Care did not submit the Critical Incident Report to the Director for fifteen (15) days.

The Director of Care indicated (to the inspector) being unable to recall why the Critical Incident Report was not submitted within ten days. [s. 107. (4)]

2. The licensee failed to comply with O. Reg. 79/10, s. 107 (5), by ensuring If there is a serious injury or serious illness of the resident, has the licensee promptly notified the resident's substitute decision-maker or any other person designated by the resident or SDM, in accordance with any instructions provided by the person(s) who are to be notified.

Related to Intake #007840-15, for Resident #002:

Progress notes (written by registered nursing staff) for a specific date indicated the following:

- On a specific date and time, Resident #002 was found (by staff) lying on the floor in resident's room. Registered Nurse (RN) #016, who was the charge nurse assessed

Resident #016 and noted the resident's injury; Resident #002 was complaining of discomfort. Registered Nurse #016 left a notation in the calendar for the next shift to contact resident's family. Resident #02 was reassessed (three hours later) by the oncoming shift (registered nursing staff) and found to be in discomfort and that his/her injuries had worsened; at which time the family was notified and resident was transferred to hospital.

Registered Nurse #016 indicated (to the inspector) that the family were not notified during the his/her shift of the incident with subsequent injury, as it was believed (by RN #016) that the injury was not severe.

The Director of Care indicated (to the inspector) that family are to be notified immediately of any incident that results in resident injury. [s. 107. (5)]

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.