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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2015	2015_282543_0003	S-000682-15	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

TIFFANY BOUCHER (543), FRANCA MCMILLAN (544), SYLVIE LAVICTOIRE (603)

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): Febraury 9-13 & February 17-20, 2015

The following logs were inspected concurrent with the RQI:
1)S-000231-14

2)S-000371-14
3)S-000311-14
4)S-000330-14
5)S-000380-14
6)S-000211-14
7)S-000448-14
8)S-000419-14
9)S-000533-14

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, conducted resident and family interviews, directly observed dining and meal delivery service, observed fluid and nourishment passes, directly observed medication passes, reviewed resident health care records, reviewed staffing patterns for RNs and RPNs and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with - Administrator
- Director of Care
- Assistant Director of Care
- Registered Staff (RNs and RPNs)
- Personal Support Workers (PSW)
- Social Worker
- Environmental Maintenance Manager
- Housekeeping Staff
- Dietitian
- Food Service Manager
- Food Service Assistant
- Scheduling Clerk
- Residents and family members

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff who provide direct care to the resident.

On February 19, 2015, spoke with #s-233 who stated that this resident does not wear any glasses, nor do they have any glasses.

Inspector #603 reviewed resident #025's care plan which identified that staff will encourage this resident to use their reading glasses and the window blinds are to be positioned as to decrease glare. The inspector identified that resident #025 does not have a pair of glasses. The inspector observed this resident sitting in a chair in their room and the window blind was opened and sun beaming and full glare seen in room. [s. 6. (1) (c)]

2. During stage 1 of the inspection process resident #041 triggered for an increase in responsive behaviours. According to this resident's most recent MDS assessment, they exhibited an increase in abusive behaviours towards staff and others.

Inspector #544 reviewed resident #041's health care record which identified that the resident has been exhibiting responsive behaviours since their admission in the fall of 2014. The inspector reviewed resident #041's progress notes from their admission to January 2015, and identified that the resident displayed many different responsive behaviours on a regular basis. Some of these incidents happened on a daily basis. It was confirmed by #s-207 and #218 that these responsive behaviours occur regularly

especially when resident #041 was provided care by staff they were not familiar with.

Inspector #544 did not identify any documentation to support that a responsive behaviour assessment was conducted for resident #041 nor were there any environmental/risk factors or conditions that may contribute to this resident's responsive behaviours documented. There was nothing to support the type and frequency or the implementation of appropriate measures related to the resident's responsive behaviours.

Inspector #544 reviewed resident #041's care plan which did not identify foci, goals or interventions to assist and/or manage these behaviours. No clear direction was identified to assist staff with providing safe care to this resident or to protect staff and other residents from these responsive behaviours. [s. 6. (1) (c)]

3. Inspector #543 reviewed Resident #002's MDS assessment specifically related to responsive behaviours, which identified that the resident displayed multiple responsive behaviours daily and these behaviours were not easily altered.

The inspector reviewed this resident's RAPS triggers which noted that the resident had responsive behaviours. These RAPS stated that these behaviours would be addressed in the care plan.

On February 18, 2015, #s-233 told the inspector that resident #002's behaviours fluctuate, up and down and can be worse at certain times of the day, but are unsure what triggers this resident's behaviours.

On February 19, 2015, #s-238 told the inspector that resident #002 does not display behaviours with them, but their behaviours may depend on the time of day.

On February 19, 2015, #s-210 told the inspector that the resident had responsive behaviours at times.

Inspector #543 reviewed this resident's care plan available to direct care staff, specifically related to responsive behaviours. The care plan did not address the responsive behaviours identified in this resident's MDS assessments and RAPS triggers. [s. 6. (1) (c)]

4. Inspector #543 reviewed resident #004's most recent MDS assessment specifically related to vision, which identified that this resident had impaired vision. The assessment

revealed that this resident sees large print, but not regular print. This resident's care plan was reviewed and noted that this resident had reduced visual acuity related to a medical condition. This resident's care plan did not reflect this resident's need for large print reading material. [s. 6. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for residents #002, #025 and #041 that sets out clear directions to staff and others who provide direct care to these residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Falls Prevention and Management Program was complied with.

Inspector #543 reviewed resident #002's most recent MDS assessment, specifically related to falls, which noted that this resident had a fall within the last 30 days as well as the last 31-180 days. The Inspector reviewed this resident's previous MDS assessment, which noted that this resident sustained an injury related to a fall. This resident's health care record identified that this resident had a history of falling. Since this resident's fall in the summer of 2014 this resident had 4 other falls.

Inspector #543 reviewed the home's Falls Prevention and Management Program. This program stated that a Morse Fall Risk assessment is completed on admission and whenever there is significant change in health status. The Inspector reviewed this resident's health care record specifically for the Morse Fall scale (Fall Risk Assessment Tool). The Inspector noted that this resident had only one Morse Fall scale completed in the autumn of 2011. No further Morse Fall scale assessments were completed for this resident after they sustained multiple falls in 2014 and 2015. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Falls Prevention and Management Program is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is kept clean and sanitary.

Inspector #544 conducted daily tours of all resident home areas and observed that the vinyl floors in the common areas, hallways and resident care areas, were dirty with built up grime, sand grit and other debris. The floors were dull in most areas of the home.

Inspector # 544 interviewed #s-222, #223 and #224 from the housekeeping department, who told the inspector that they do not vacuum the floors, only the carpet areas. They spot clean the floor of any spills during the day in the hallways, and residents' room floors are washed daily. The maintenance person, on afternoon shift, washes the main hallway floors, entry floors and other common areas with the "machine".

Inspector #544 spoke with #s-221, who confirmed that in a resident care area, this was not done. The scrubber machine had been broken about six months ago but is now in use once again. They told the inspector that a maintenance person, is to stop the scrubber and manually remove any dirt or grime from the floors. They confirmed that the corners of the floors on the main level were full of debris, sand and black grime that had not been cleaned on a daily basis and that the floors were dull and lacked luster.

Inspector #544 observed #s-227 using the scrubber to wash the floors in the main hallways of the home. The inspector observed that the scrubber machine got very close to the walls and corners and picked up the gravel and dust. At no time did the worker leave his machine to spot clean any difficult dirt areas that were not removed by the scrubber. Inspector observed that staff # 227 did not have any cleaning supplies with him in order to spot clean any difficult areas of dirt and grime.

Inspector #544 spoke with #s-222 and #223 who stated that they spray a cleaner on the floors in the dining room of each resident care area and resident rooms. This spray lifts off the dirt and stains and then the floors are wet mopped, at no time are the vinyl floors vacuumed. Staff # 222 informed the inspector that they can't spend too much time on the floors in a specific resident area due to residents who are frequently up and about.

Inspector # 544 conducted a walk about with #s-221 in resident care areas and noted:
- old accumulated stains on the floor in front of the soiled utility room
- black grime in the cracks on the floor in front of a resident's room
- other old stains throughout the hallway
- large amount of dust along ledges of the doors with windows in hallways, dining area and TV rooms
- large amount of dust on wooden ledges above the hand railings
- stained flooring in a resident room
- obvious grime in front of a soiled utility room
- dust and stains on the flooring in front of several resident rooms
- cracked vinyl where floor turns into the baseboard between rooms and cracks filled with black grime
- sand and gravel all along the edge of the floor in a large care area

Inspector #544 interviewed #s-236, who told inspector that he was brought in extra to work on cleaning the grime in the corners of the hallways and the area in front of the doorways of residents' rooms where the scrubber does not reach. [s. 15. (2) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Inspector #544 interviewed, resident #042, who stated that approximately a month ago, a PSW was verbally abusive towards them. On a night shift, resident #042 pulled the call bell to call for assistance. The PSW provided care in a rough manner, to assist them and did not allow the resident enough time to finish what they were doing. Resident #042 stated that it takes them a long time, but they like to be independent and do things on their own as much as they can.

Resident #042 stated that #s-213 spoke loudly and roughly towards them and had a "rough attitude" towards them. The resident stated that #s-213 made them feel like they were a nuisance and they felt humiliated. They stated that they asked the staff member their name, but got no response.

Inspector #544 reviewed the progress notes relating to the incident which indicated the following: Resident notified writer that approximately 4 days ago, on night shift, the PSW provided care inappropriately and they have been having pain ever since. The RN was made aware. A note was left on the doctor's board to assess. There was no other documentation in resident #042's progress notes or health care records regarding this incident or any documentation of any follow-up by the home. Inspector #544 spoke with #s-215 who stated that they recalled resident #042 informing them of the incident, and then they reported it to #s-212.

On February 12, 2015, Inspector #544 reported the above mentioned incident to #s-209. On February 17, 2015, the inspector spoke with #s-209 who confirmed they had not sent in a critical incident report, in regards to the allegation of verbal abuse by #s-212 towards resident #042 nor was there an investigation relating to this matter.

On February 17, 2015, Inspector #544 spoke with resident #042. They stated that

#s-209 had not approached them about the incident of verbal abuse by #s-212. [s. 19. (1)]

2. On February 20, 2015, Inspector #603 reviewed a critical incident relating to #s-239 abusing a resident. Inspector #603 reviewed the home's investigation, which revealed that #s-239 admitted to abusing the resident and was initially issued an unpaid discipline and later terminated for the same action. [s. 19. (1)]

3. On February 20, 2015, Inspector #603 reviewed a critical incident report that was submitted due to a report received by an instructor from a student alleging that #s-240 had been rough, rude, provided inadequate care, and spoke inappropriately to and about residents during a student placement. The student reported the incident to their instructor and the instructor brought the concerns to the home.

Upon the home's investigation, it was revealed that although the investigation was unable to prove or disprove specific actions on the part of the staff, the staff in question was disciplined as the concerns corroborated a pattern of behavior that had been identified in the past for which the staff had already been disciplined. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents in the home are protected from abuse and/or neglect by the licensee and staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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. (2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #544 interviewed, resident #042 who stated that approximately a month ago, a PSW was verbally abusive towards them. On a night shift, resident #042 pulled the call bell to call for assistance. The PSW provided care in a rough manner, to assist them and did not allow the resident enough time to finish what they were doing. Resident #042 stated that it takes them a long time, but they like to be independent and do things on their own as much as they can.

Resident #042 stated that #s-213 spoke loudly and roughly towards them and had a "rough attitude" towards them. The resident stated that #s-213 made them feel like they were a nuisance and they felt humiliated. They stated that they asked the staff member their name, but got no response.
Inspector #544 reviewed the progress notes relating to the incident which indicated the following: Resident notified writer that approximately 4 days ago, on night shift, the PSW provided care inappropriately and they have been having pain ever since. The RN was made aware. A note was left on the doctor's board to assess. There was no other

documentation in resident #042's progress notes or health care records regarding this incident or any documentation of any follow-up by the home. Inspector #544 spoke with #s-215 who stated that they recalled resident #042 informing them of the incident, who then reported it to #s-212.

On February 12, 2015, Inspector #544 reported the above mentioned incident to #s-209. On February 17, 2015, the inspector spoke with #s-209 who confirmed they had not sent in a critical incident, in regards to the allegation of verbal abuse by #s-212 towards resident #042 nor was there an investigation relating to this matter. [s. 24. (1)]

2. Inspector #603 reviewed a critical incident which indicated that #s-239 abused resident #036. The incident occurred in the "middle of the evening shift" in September 2014. The CI report was submitted on the next day.

Inspector #603 interviewed #s-209 who could not explain why the report had not been filed earlier. The same staff explained that it is the home's policy to report any abuse immediately. If an event such as abuse were to happen after hours, there is always management staff on call to deal with such events.

Inspector #603 reviewed documentation dated September 4, 2014, which indicated that #s-241 had witnessed the incident and not reported the event because they feared retaliation from staff #s-239. [s. 24. (1)]

3. On February 13, 2015, Inspector #603 reviewed a critical incident report. In November 2013, a student had reported to an instructor, concerns that #s-240 was rough, rude, and provided inadequate care towards residents. The instructor reported findings to the home in January 2014.

Inspector #603 also reviewed the homes' orientation program for students which indicated that all students are required to report any conduct that they see or hear about that may pose a risk of harm to residents, staff, volunteers, and family members or to the operation of facility. The purpose of this policy is to ensure compliance with reporting and whistle-blowing provisions of the LTCHA. The homes' policy on Zero Tolerance for Abuse and Neglect indicated that any employee or volunteer who witnesses, or becomes aware of, or suspects resident abuse shall report it immediately to the Director of Care/Administrator/delegate.

On February 13, 2015, Inspector #603 spoke with #s-209 who explained that all staff,

volunteers, students, and instructors all receive training on resident rights, duty to protect, zero tolerance for abuse and neglect, and reporting. The home provides orientation and training to all students and instructors at the start of every placement. An orientation package is specific to the students and instructors. [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 that when a person who has reasonable grounds to suspect that;
a)Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; and/or

b)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,

shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received annual retraining relating to the home's policy regarding the prevention of abuse

Inspector #543 spoke with the Administrator regarding education specifically relating to Prevention of Abuse. The Administrator stated that the home is presently upgrading their tracking system for keeping accurate records of staff members who have attended the education sessions. They also stated that the home has hired a corporate educator to facilitate the task of tracking education. The Administrator confirmed that not all staff in the home have received annual training relating to mandatory programs, such as but not limited to Prevention of Abuse and Falls Prevention. [s. 76. (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 shall ensure that all staff at the home have received retraining related to promoting the prevention of abuse and neglect and Falls Prevention as required by the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #544 reviewed a complaint received from a resident #050's family member, regarding allegations that staff were not providing the basic care to their family member.

Inspector #544 reviewed resident #050's health care record, specifically related to PSW documentation of tasks completed for this resident. This documentation identified that at times resident #050 was not given their bath at times and had to wait a long time for care and services when they pulled the call bell.

Inspector #544 reviewed a complaint regarding call bells not being answered in a timely fashion and alleged neglect of residents; not being toileted or receiving personal care due to the shortage of staff. The complainant also mentioned a resident, who had eloped from a resident care area, in which the staff response time was 2 minutes and the complainant felt that this situation should have been identified earlier by staff.

Inspector #544 spoke with a resident's family member who stated that there was only one PSW scheduled, during the night shift, on a specific unit. They felt that was not enough staff, and stated that their family member stated having to wait long periods of time for their call bell to be answered.

Inspector #544 spoke with #s-219, #222, #224 and #226 who all confirmed that when the resident care areas were short staffed, those staff members who worked, would have to have their workload increased. They also confirmed that baths would be missed and confirmed that it does take longer to answer call bells or transfer residents who required the assistance of more than one staff member.

Inspector # 544 reviewed the staffing pattern for all the resident care areas in the home. The inspector interviewed #s-207 and #210 in regards to the home's staffing pattern who confirmed that the following staffing pattern is accurate:

Resident Care Area "A"
Days: 4 PSW, 1 RPN and 1 float RN
Evenings: 4 PSW, 1 RPN and 1 float RN
Nights: 1 PSW, 1 float between 2 home areas, 1 RN floats between 2 resident care areas

Resident Care Area "B"
Days: 4 PSW, 1 RPN and 1 float RN
Evenings: 5 PSW, 1 RPN and 1 float RN
Nights: 1 PSW, 1 float between 2 home areas, 1 RN floats between 2 resident care areas

Resident Care Area "C"

Days: 4 PSW, 1 RPN and 1 float RN
Evenings: 3 PSW, 1 RPN and 1 float RN
Nights: 1 PSW, 1 float between 2 home areas, 1 RN floats between 2 resident care areas

Resident Care Area "D"
Days: 4 PSW, 1 RPN and 1 float RN
Evenings: 3 PSW, 1 RPN and 1 float RN
Nights: 1 PSW, 1 float between 2 home areas, 1 RN floats between 2 resident care areas

Inspector #544 reviewed the staff scheduling for the PSWs and found several unassigned PSW shifts that were not replaced. The inspector interviewed #s-225 who confirmed that the "unassigned shifts" were the shifts that were not covered or replaced when the staff persons called in sick or did not show up for work. Therefore, staff in the resident care areas worked short which meant they were given extra residents to care for. The Inspector reviewed shift coverage for each resident care area, from November 1, 2014, to December 2, 2014, which were as follows:

Resident Care Area "A"

-5 days shifts were short 1 PSW
-5 evening shifts were short 1 PSW
-1 night shift was short 1 PSW

Resident Care Area "B"

-4 day shifts were short 1 PSW
-10 evening shifts were short 1 PSW

Resident Care Area "C"

-3 day shifts were short 1 PSW
-4 evening shifts were short 1 PSW
-8 night shifts were short 1 PSW

Resident Care Area "D"

-6 day shifts were short 1 PSW
-3 evening shifts were short 1 PSW

A total of 51 shifts were short Personal Care Aides from November 1, 2014 to December 2, 2014.

Inspector # 544 interviewed #s-200 who stated that recruitment of PSWs is an ongoing process and that there are vacancies for 8 PSWs. They stated that recruitment and retention of staff is a continuous challenge. [s. 8. (1) (b)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse and/or neglect of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.

Inspector #544 interviewed resident #042 who stated that a Personal Support Worker (PSW) was verbally abusive towards them. The resident stated, that on a night shift, they pulled the call bell to call for assistance. The PSW provided care in a rough manner, to assist them and did not allow the resident enough time to finish what they were doing. Resident #042 stated that it takes them a long time, but likes to be independent and do things on their own as much as they can.

Resident #042 stated that #s-213 spoke loudly and roughly towards them and had a "rough attitude" towards them. The resident stated that #s-213 made them feel like they were a nuisance and they felt humiliated. They stated that they asked the staff member their name, but got no response.

Inspector #544 reviewed the progress notes relating to the incident which indicated the following: Resident notified writer that approximately 4 days ago, on night shift, the PSW provided care inappropriately and they have been having pain ever since. The RN was made aware. A note was left on the doctor's board to assess. There was no other documentation in resident #042's progress notes or health care records regarding this incident or any documentation of any follow-up by the home. Inspector #544 spoke with #s-215 who stated that they recalled resident #042 informing them of the incident, who then reported it to #s-212.

On February 12, 2015, Inspector #544 reported the above mentioned incident to #s-209. On February 17, 2015, the inspector spoke with #s-209 who confirmed they had not sent in a critical incident, in regards to the allegation of verbal abuse by #s-212 towards resident #042 nor was there an investigation relating to this matter.

On February 17, 2015, Inspector #544 spoke with resident #042. They stated that #s-209 had not approached them about the incident of verbal abuse by #s-212. [s. 23. (1) (a)]

WN #9: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's plan of care was based on an interdisciplinary assessment with respect to the resident's risk of falls.

Inspector #543 reviewed this resident's most recent plan of care specifically related to falls. The goal for this resident was to minimize the risk for falls, with interventions that would minimize the risk of falls and injury as a result of falls. This resident's plan of care was not updated to indicate this resident's history of falls, recent injury and/or change in health status.

Inspector #543 reviewed this resident's health care record specifically for Morse Fall scale (Fall Risk Assessment Tool). The Inspector noted that this resident had only one Morse Fall scale completed in the fall of 2011. No further Morse Fall scale assessments were completed for this resident after they sustained multiple falls between 2014 and 2015. [s. 26. (3) 10.]

WN #10: 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 has failed to ensure that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

During stage 1 of the inspection process resident #041 triggered for an increase in responsive behaviours. According to this resident's most recent MDS assessment, they exhibited an increase in abusive behaviours towards staff and others.

Inspector #544 reviewed resident #041's health care record which identified that the resident has been exhibiting responsive behaviours since their admission in the fall of 2014. The inspector reviewed resident #041's progress notes from their admission to January 2015, and identified that the resident displayed many different responsive behaviours on a regular basis. Some of these incidents happened on a daily basis. It was confirmed by #s-207 and #218 that these responsive behaviours occur regularly especially when resident #041 was provided care by staff they were not familiar with. The resident has been demonstrating these responsive behaviours since their admission and these behaviours are now escalating and no documentation could be found in the plan of care to manage the behaviours. Nor were there any focus goals or interventions to manage these escalating responsive behaviours in resident #041's plan of care. There was no clear direction to assist staff with providing safe care to resident #041 and to protect staff and other residents from these responsive behaviours exhibited by the resident.

Inspector #544 reviewed resident #041's health care record. There was no documentation to support that strategies were developed and implemented to respond to

the resident. This was confirmed by #s-218 and #207. Nor were there any environmental risk factors or conditions identified that may contribute to responsive behaviours documented.

There was no other documentation to support type and frequency of staff support nor documentation to support the implementation of appropriate measures related to resident #041's responsive behaviours. This was confirmed by staff #s-218 and #207.

Inspector #544 reviewed resident #041's plan of care and identified that the plan of care was not based on the goals, needs and strengths specific to the resident and did not reflect a comprehensive assessment in regards to their responsive behaviours. This was confirmed by #s-218 and #207.

Inspector #544 reviewed all the assessments that resident #041 had to date, and identified that a Mini mental assessment, conducted in 2014 which identified that this resident was severely cognitively impaired.

In 2014, resident #041 was on Dementia Observation Charting (DOS) charting due to an incident of responsive behaviours towards staff. The only documentation for this incident was done by the staff on the day shift and then it was discontinued.

According to the home's Responsive Behaviours policy, other screening tools for responsive behaviours may include:

- Depression in Dementia
- Elopement risk
- Pain assessment
- PIECES suite of tools
- Cornell scale for depression
- Cohen Mansfield Agitation Inventory
- Folstein mini-mental assessment (MMSE)
- Montreal Cognitive Assessment (MoCA)
- Dementia Observation System (DOS)

Inspector did not find any other documentation in the progress notes, assessments tab of Point Click Care (PCC), or the health care record to support that resident #041 had any of the other assessments listed above were conducted. The home's policy stated that residents can be referred to services such as Behavioural Support Ontario (BSO),

Psychogeriatric Resource Consultant, Senior Mental Health Outreach Team, Geriatric Psychiatry Outreach Consultation Services, MOHLTC High Intensity Needs or North Bay Regional Health Centre. Referrals to these services can be done by the Registered staff and does not require a doctor's order. This was confirmed by #s-218. This staff member also told the inspector that they felt the resident did not need these referrals because the resident only demonstrated these behaviours with staff or people that they did not know. The staff member confirmed that responsive behaviours would be added to resident #041's care plan.

There was no documentation to support that a responsive behaviour assessment was conducted for resident #041 which was confirmed by #s-218 and #207. Nor had the resident's behavioural triggers been identified or strategies been developed, or implemented to respond to the resident's responsive behaviours. [s. 53. (4) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the weekly menus are communicated to residents.

On February 9, 2015, Inspector #603 observed the posted weekly menu in the dining room which indicated week 3 (Fall and Winter 2014-2015), yet week 2 was being served. The inspector spoke with #s-208 who stated that they forgot to change the weekly menu to week two. The inspector observed the posted weekly menu in another dining room which indicated week 4 (Spring and Summer 2014), yet week 2 was being served.

Inspector #603 interviewed #s-204 who stated that it is the home's policy to change the weekly menu every week. This staff member confirmed the existing posted menu was incorrect. [s. 73. (1) 1.]

2. The licensee has failed to ensure that staff assisting residents are aware of the

resident's diets, special needs and preferences.

On February 9, 2015, Inspector #603 observed the dining room services. During this time, resident #027 was observed eating pureed food with their hands and there were no utensils available for this resident.

Inspector #603 interviewed #s-201 in regards to the resident not having any utensils for eating and the staff responded by saying they did not know, nor did they know the resident as this was not the floor that they usually work on. This staff member proceeded to get utensils and could not find an appropriate size spoon and gave the resident a large spoon that they found on the server's counter. The resident proceeded to eat with the spoon and finished the food within minutes.

Inspector #603 requested the floor plan and the resident's food plan for likes and dislikes and nourishment form and #s-201, #202, or #203 did not know where the forms were located and stated that they do not utilize the forms as not necessary. They claimed to know the residents well enough that they do not need the forms.

Inspector #603 interviewed #s-204 who explained that it is the home's practice to have all forms attached to the servery and refer to them when serving the residents; they also explained that when there is new staff working the unit, they are to look at the resident care plans to familiarize themselves with the residents before caring for them. [s. 73. (1) 5.]

3. The licensee has failed to ensure a proper technique including safe positioning is used to assist a resident with eating.

On February 9, 2015, Inspector #603 observed resident #026 to be tilted back in a wheelchair while eating in the dining room. The resident was having difficulty drinking from a cup. The inspector interviewed #s-201 who explained that the resident needs to be tilted in the wheelchair for positioning and if not, they will slide off from the wheelchair.

On February 10 and 11, 2015, Inspector #603 observed resident #026 sitting upright in the wheelchair and was able to drink from a cup with ease. Inspector #603 reviewed this resident's care plan which did not identify the resident having to sit in a tilted wheelchair for meals. [s. 73. (1) 10.]

4. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

On February 9, 2015, Inspector#603 observed #s-203 feeding three residents at the same time, they were standing up and would go around the table alternating feedings between three residents. The inspector spoke with this staff member who stated that at times, they have no choice but to feed more than 2 residents since there is not enough staff and the resident's food would be cold.

On February 9, 2015, while observing dining services, Inspector #603 was approached by resident #031's family member who was visiting and feeding the resident. The family member explained that there is often not enough staff to help feed residents, which is the reason they come in at every meal to help feed resident #031.

On February 10, 2015, Inspector #603 interviewed #s-204 who confirmed that it is the home's expectation that staff will not feed more than 2 residents at a time. [s. 73. (2) (a)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Inspector #544 interviewed the Chairperson of the Family Council. The Chairperson told the inspector that the Family Council was not asked for the Council's advice in developing and carrying out the satisfaction survey and in acting on its results and would like the opportunity to do this. They stated, "The home does not seek our advise on any matter."

Inspector interviewed #s-200 who told the inspector that the satisfaction survey was developed by the Quality Assurance staff person. The administrator thought that there were family members on the committee that developed this survey approximately three years ago but not recently. #S-200 confirmed that the home did not seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results. #s-200 agreed with the Chairperson of the Family Council and will take steps to ensure that this opportunity is given the Family Council.

Inspector # 544 interviewed the Chairperson of the Family Council. The Chairperson told the inspector that the Family Council was not asked for the Council's advice in developing and carrying out the satisfaction survey and in acting on its results and would like the opportunityto do this. [s. 85. (3)]

2. The licensee has failed to ensure to seek the advice of the Family Council about the satisfaction survey.

Inspector # 544 interviewed the Chairperson of the Family Council. The Chairperson told the inspector that the Family Council was given a copy of the satisfaction survey but the home does not seek the advice of the Council about the survey. The Chairperson of the Family Council told the inspector, "The home does not seek our advice on any matter."

Inspector interviewed #s-200 who confirmed that the satisfaction survey results were given to the Family Council. #S-200 confirmed that the home did not seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results. This staff member told the inspector that she will take steps to ensure that with the next survey, the home will include and seek the advice of the Family Council regarding the satisfaction survey. [s. 85. (4) (a)]

WN #13: 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. The licensee has failed to ensure that the report to the Director included the names of any staff members who were involved in the incident.

On February 20, 2015, Inspector #603 reviewed Critical Incident that was submitted to the Director. The CI was submitted due to a report received by an instructor from a student alleging that a staff member had been rough, rude, offered inadequate care, and spoke inappropriately to and about a resident during a student placement. The critical incident did not include that name of the staff member involved or the name of the student who had filed the concerns. The home conducted an investigation which identified #s-240. Inspector #603 reviewed a letter addressed to this staff member which indicated that a critical incident was going to be filed with the MOHLTC. The inspector also reviewed the student's letter detailing the allegations.

The inspector reviewed the homes' policy on Zero Tolerance for Abuse and Neglect and Appendix B (2) which indicated that a description of the individuals involved in the incident includes ii) names of any staff members or other persons who were present at or discovered the incident [s. 104. (1) 2.]

WN #14: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after resident #007 fell in the home and sustained an injury that resulted in a transfer to hospital.

Inspector #543 reviewed this resident's progress notes specifically related to a fall that occurred. These notes revealed that this resident arose from their chair and fell striking their head. The home called the ambulance and the resident was transferred to hospital.

A critical incident report was not initiated until three days after the incident occurred. [s. 107. (3) 4.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider until administered to a resident.

On February 18, 2015, Inspector #603 observed #s-231 do their medication pass. The staff explained that all narcotics to be administered on that shift had been pre-poured and signed off by #s-212, who was originally scheduled to administer all medications, however had now been pulled to do MDS work. An arrangement was made between these two staff members, that #s-231 would administer the regular medications and #s-212 would administer the pre-poured narcotics as scheduled.

Inspector #603 interviewed #s-212 who explained that pre-pouring medication is against the home's policy, and explained that all narcotics are to be poured at the time of administration. [s. 126.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area.

On February 18, 2015, Inspector #603 observed that the prn narcotic medication drawer was unlocked in one of the resident care area medication rooms. The inspector interviewed #s-212 who could not explain why the prn narcotic drawer was unlocked, but confirmed that it is to be locked at all times. [s. 129. (1) (b)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On February 18, 2015, Inspector #603 observed #s-231 administer medication to resident #032 in the room adjacent to one of the dining rooms. The staff administered one medication tablet by mouth and opthalmic drops, one drop in each eye. The physician's order for the opthalmic drops was; give 2 drops in left eye three times a day. Inspector #603 reviewed this resident's medication administration records, which indicated to give medication pc lunch (after eating). The resident did not have lunch at the time of medication administration. The inspector spoke with #s-231 stated that "pc" meant giving medication before lunch. [s. 131. (2)]

Issued on this 14th day of May, 2015

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

Original report signed by the inspector.