Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2018	2018_664602_0004	002525-18, 002989-18, 003332-18, 003379-18	Complaint

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 BROCKVILLE ON K6V 5T1

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

St. Lawrence Lodge
1803 County Road, #2 East Postal Bag #1130 BROCKVILLE ON K6V 5T1

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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 9, 2018, February 26-28, 2018, March 2, 2018 and March 7-9, 2018.

The following intakes were reviewed during this inspection:
Log # 002525-18 concerning foot/nail care
Log # 002989-18 concerning plan of care, medication management and alleged neglect
Log # 003332-18 concerning alleged abuse/neglect
Log # 003379-18 concerning repositioning, skin/wound care, and housekeeping

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), environmental services, the Assistant Directors of Care (ADOC1, 2 & 3), and the Director of Care (DOC)

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect resident #002 from neglect by staff.

The following finding is related to Log # 003332-18:

For the purpose of the definition of "Neglect" in subsection 2(1) of the Act, Neglect is defined in
O.Regs 79/10 s. 5 as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

On a specified date, resident #002's Substitute Decision Maker (SDM) informed the Director of an incident of neglect via the Ministry Action Line. Resident #002 did not receive required care for a significant length of time resulting in resident 002's pain, distress and potential physical injury. Upon discovery of the neglect the Registered Nurse (RN) was alerted and an assessment was conducted. The RN expressed concern regarding the resident's discomfort possible trauma in a summary of the incident. The DOC received the summary a specified period of time later.

Resident #002's care plan at the time of the incident indicated that total assistance was required for specified care.

Assistant Director of Care (ADOC) #104 explained that management was informed of the incident on a specified date. The ADOC indicated that the incident was not reported to the Director or the SDM, but an internal investigation was started. The investigation conducted by the licensee confirmed that Personal Support Worker (PSW)s #106 & #107 had failed to provide required care. The incident was not reported immediately to the Director or the SDM nor was it reported immediately internally, contrary to legislation and licensee policy. The SDM was alerted via telephone call from ADOC #104 a specified period of time later. The licensee did not report the incident to the Director. No action was taken to protect residents from being neglected by PSW #106 and #107 as both PSWs continued to work directly with residents, thus, the licensee failed to comply with:
1. Duty to protect – LTCA s. 19. (1) The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by staff. 2007, c. 8, s. 19 (1). (refer to WN #001)
2. Plan of Care - LTCA s. 6. (9). The licensee shall ensure that the following are documented: The provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, and the effectiveness of the plan of care. 2007, c. 8, s. 6 (9). (refer to WN #002)
3. Policy to promote zero tolerance - LTCA 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) (refer to WN #003)
4. Licensee must investigate, respond and act – LTCA s. 23. (1) Every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee is immediately investigated, appropriate action is taken in response to every such incident and any requirements that are provided for in the regulations for investigating and responding are complied with. (refer to WN #004).
5. Reporting certain matters to Director – LTCA s. 24. (1) A person who has reasonable grounds to suspect that abuse and/ or neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. (refer to WN #005).
6. Notification re incidents – O. Reg. 79/10, s. 97 (1) (a) 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 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. (refer to WN #007). [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the provision, outcome and effectiveness of specified assessments, treatments and specified care including bathing, nail care, and

safety monitoring as set out in resident plans of care were documented.

A) Resident #007 was admitted to the home on a specified date. The resident required specified assessments, treatments and other related care.

A registered dietician note indicated that resident #007 had significant, multiple care needs. A physician's note indicated that resident #007's care must be monitored carefully. Resident #007's SDM advised inspector #602 that hospital staff had expressed concern regarding poor care provided at the home.

The licensee's policy and procedure specific to specified assessments and treatments instructs registered nursing staff to initial treatment interventions on the Treatment Assessment Record (TAR) record. It further directs registered nursing staff to complete specified assessments.

A specified number of assessment tools were reviewed; assessments were not completed for Resident #007's on a specified number of days..

ADOC #120 was interviewed and it was agreed that a number of assessments and treatments respectively had not been documented. Four of the required assessments were not documented as well as five treatments. ADOC#120 acknowledged that due to missing documentation, there was no evidence to support that weekly assessments and multiple treatments set out in the plan of care were provided, nor was the outcome or effectiveness of the care documented.

B. Resident #007's care plan contains numerous interventions including specified care every two hours and frequent monitoring for injury.

A review of resident #007's flow sheets indicated that resident #007 was not provided with specified care on over sixty percent of shifts. ADOC #120 acknowledged that it is the home's expectation that staff follow the care plan, and that missing documentation disallowed confirmation that care was provided.

Several PSW staff were interviewed and each indicated that they were aware that completed care is to be documented on flow sheets. The PSW's acknowledged, that given the lack of documentation, they could not confirm that resident #007 had been cared for as directed in the care plan during a specified period. The DOC agreed, in a subsequent interview, that without documentation, care provision, outcome and

effectiveness could not be confirmed

C. Resident 006's care plan indicates bathing is required twice a week with the physical assistance of one staff. The plan further requires that nail care is completed.

During an interview, ADOC #101 confirmed that their Nail Care policy #0401-03-18, required that cleanliness and proper trimming of nails are assessed daily during dressing and weekly on bath days, and that PSWs are to trim/care for fingernails and toenails during resident #006's bath.

On a specified date, the DOC #100 reviewed a specified number of resident #006's personal care flow sheets and acknowledged that there was no documentation specific to nail care for 95% of possible check boxes. Nail Care policy #0401-03-18 indicates nails are to be assessed once a day while washing a resident's hands or bathing and that they are to be trimmed minimally weekly with sign off on flow sheets. DOC #110 agreed both bathing and nail care sections were not signed off and acknowledged that management need to work with staff to improve documentation of the care provided.

D. As of a specified date, resident #009 had fallen a specified number of times in a specified period during which the resident resided in the home. The care plan indicated that resident #009 was to receive certain fall related interventions including specific care and safety monitoring. Three PSW staff were interviewed and each indicated their awareness that resident care should be provided as outlined in the plan of care as well as documented for monitoring and ensuring safety. Each PSW acknowledged that, given the lack of documentation, they could not confirm that resident #009's care and safety monitoring.

In an interview, DOC #100 indicated upon review of resident #009's flow sheets, that incomplete documentation did not allow confirmation that the provision, outcome and effectiveness of care and regular safety monitoring was completed during the time periods reviewed..

In an interview on a specified date, ADOC #120 acknowledged that it is the expectation of staff to follow the care plan. It was explained that if someone is to be provided specific care and certain safety measures are to be in place then the provision of care should be documented. The current documentation audit process was reviewed and multiple misses were noted to be ongoing, despite verbal and written warnings.

A review of resident 009's flow sheets indicated that each two week form had multiple periods where care provision was not documented. There were no staff initials indicating the care had been provided and safety measures were in place as per care plan during 80% of the time period prior to the fall. Care and monitoring were not reliably being documented on the specified flow sheets. [s. 6. (9)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure their Abuse and Neglect of Resident's policy 0202-02-05 was complied with, specifically the direction outlined under: Purpose, pg. 2 of 7. "The purpose of the policy on abuse and neglect of residents by employees/volunteers/visitors/ residents is to provide:
- an appropriate and prompt process to report investigate and address allegations of abuse and neglect of residents."

The following finding is related to Log # 003332-18:

The licensee failed to ensure their MOHLTC Mandatory and Critical Incident Reporting policy 0202-12-01 was complied with specifically A-Mandatory Reports Requiring Immediate Reporting Table A – "abuse of a resident by anyone or neglect of a resident by licensee or staff that resulted in harm or risk of harm to the resident" requires staff "immediately initiate and submit an on line MOHLTC Critical Incident System report. Identify as a "mandatory report" .

On a specified date, resident #002 did not receive required care for a significant length of time causing the resident discomfort, distress and potential for injury. Upon discovery of the neglect registered staff was alerted and an assessment was conducted. The registered staff expressed concern regarding the lengthy period in which the care was not provided and for possible trauma to the resident. A summary of the incident was completed by the RN and received by the DOC a specified period of time later.

Contrary to Policies: Abuse and Neglect of Resident's policy 0202-02-05 and MOHLTC Mandatory and Critical Incident Reporting policy 0202-12-01, the incident was not reported to the Director or internal management immediately. Delayed reporting disallowed an immediate investigation and did not support the implementation of appropriate actions to protect other residents from neglect by PSW #106 & #107 while management staff conducted their late investigation. [s. 20. (1)]

WN #4: 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 very alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:

The following finding is related to Log # 003332-18:

On a specified date, resident #002 did not receive required care for a significant length of time causing the resident discomfort, distress and potential for injury. Upon discovery of the neglect registered staff was alerted and an assessment was conducted. The RN expressed concern regarding the lengthy period in which the care was not provided and for possible trauma to the resident. A summary of the incident was completed by the RN and received by the DOC a specified period of time later. The RN alerted ADOC #104 via a message which was received a specified period of time later.

Contrary to Policies: Abuse and Neglect of Resident's policy 0202-02-05 and MOHLTC Mandatory and Critical Incident Reporting policy 0202-12-01, the incident was not reported to the Director or internal management immediately delaying the commencement of an investigation and the taking of appropriate actions to protect other residents from neglect by PSW #106 & #107 while management staff conducted their late investigation.. [s. 23. (1) (a)]

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

The following finding is related to Log # 003332-18:

On a specified date ADOC #104 advised that internal management was informed of the critical incident (CI) on a specified date. The ADOC confirmed that the incident was not reported to the Director or the SDM immediately or a subsequent time period later The SDM was informed by telephone a specified period of time later. Despite home management staff awareness of the neglect that occurred on a specific date, the Director was not immediately alerted to the incident on discovery.. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 received preventive and basic foot care services, including the trimming of toenails, to ensure comfort and prevent infection.

The following finding is related to log #002525-18:

On a specified date resident #006's SDM explained that the home had not clarified when, how often and by whom, resident 006's foot care was being provided. The SDM had understood that specialized nail care would be provided every four weeks and that nail trimming needs and cleanliness was assessed and dealt with at least weekly. The "last charted" foot care the resident received was a specified number of months previous, indicating to the SDM that neither the monthly, nor the weekly care was being provided.

ADOC #101 confirmed that the Nail Care Policy #0401-03-18, requires that cleanliness and proper trimming of nails are assessed daily during dressing and weekly on bath days and that PSWs are to trim and/or otherwise care for toenails during twice weekly baths. ADOC #101 also confirmed that a foot care podiatrist comes to the home every seven weeks and offers specialized nail care to unit residents.

During an interview Registered Practical Nurse (RPN) # 124 indicated that basic toenail trimming is completed by PSWs on bath days, as required, twice weekly. RPN# 124 confirmed that this is the role of PSWs when caring for certain residents. In a subsequent interview, PSW #125 confirmed that toenail care is provided on bath days at least weekly, however, residents sometimes refuse their bath. PSW #125 confirmed that toenail care should still be provided even when a bath is refused as per the residents plan of care and nail care policy.

A review of resident #006's flow sheets indicate that toenail care was provided thirty percent of the time during a specified period.

The licensee failed to ensure that resident #006 received preventive and basic foot care services. [s. 35. (1)] [s. 35. (1)]

2. The following finding is related to log #002525-18:

The licensee has failed to ensure that resident #006 received fingernail care, including the cleaning and trimming of fingernails.

On a specified date resident #006's fingernails were observed and food debris was noted under the left long thumb nail, left pointer and both ring fingers. At a subsequent meeting, after resident #006 had been assisted to get up and washed for the day, it was noted that resident #006's fingernails had not been trimmed and the same debris noted previously under the left thumb nail, left pointer and both ring fingers was present.

ADOC #101 confirmed that Nail Care policy #0401-03-18, requires that cleanliness and proper trimming of nails are assessed daily during dressing and weekly on bath days; PSWs provide fingernail care.

On March 2, 2018 RPN # 124 indicated that basic nail trimming is completed by PSWs on bath days as required weekly. RPN #124 confirmed that this is the role of PSWs when caring for resident #006. In a subsequent interview, PSW #125 confirmed that fingernail care is provided on bath days at least weekly, however, sometimes residents refuse a bath.

Inspector #602 reviewed the licensee's Nail Care policy #0401-03-18, review date: June 2017. On page 1 of the policy it states "assess each residents nails daily during dressing and weekly during bathing to identify potential problems". The procedure includes directions to trim fingernails minimally weekly with scissors or clippers and to tick off and sign flow sheet in the appropriate column.

A review of resident #006's flow sheets indicate that fingernail care was provided thirty percent of the time over a specified period. ADOC #101 acknowledged that there was no evidence to support that fingernail care had been completed.

The licensee failed to ensure that resident #006 received fingernail care, including the daily assessing and at least weekly trimming of fingernails. [s. 35. (2)]

WN #7: 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 following finding is related to Log # 003332-18:

The licensee has failed to ensure that resident #002's SDM was notified immediately upon becoming aware of alleged neglect of the resident that resulted in pain and distress that could potentially be detrimental to resident #002's well-being;

Resident #002's SDM was notified of an incident involving neglect on as specified date, a specified length of time after the incident was discovered. ADOC#102 advised the SDM, via telephone, that an investigation was conducted and confirmed that two PSW staff failed to provide required care over a significant length of time. Despite home management staff awareness of the incident on a specified date, the SDM was not immediately alerted to the incident on discovery. [s. 97. (1) (b)] [s. 97. (1) (b)]

Issued on this 20th day of June, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602)
Inspection No. / No de l'inspection :	2018_664602_0004
Log No. / No de registre :	002525-18, 002989-18, 003332-18, 003379-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 28, 2018
Licensee / Titulaire de permis :	The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott c/o St. Lawrence Lodge, 1803 County Road 2, BROCKVILLE, ON, K6V-5T1
LTC Home / Foyer de SLD :	St. Lawrence Lodge 1803 County Road, #2 East, Postal Bag #1130, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Harrington

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, S.O. 2007, c. 8, s. 19 (1).

Specifically, the licensee shall ensure that:
a) A written process that ensures resident #002 and all other residents requiring specified toileting care are provided this care by the same staff member, or, when necessary, the care is formally transferred to another staff by the original staff member, is developed and implemented.
b) Education is provided to management and direct care staff specific to Policy 0202-02-05 Abuse and Neglect of residents and related legislation, in addition to annual education, that highlights:
a. Definition of neglect and abuse
b. Requirements specific to responding (2007, c. 8, s. 23 (1).), reporting (2007, c. 8, s. 20 (1)., 2007, c. 8, s. 24 (1). and O. Reg. 79/10, s. 97 (1).) and investigating (2007, c. 8, s. 23 (1).) every alleged, suspected or witnessed incident of resident abuse or neglect by staff.

Grounds / Motifs :

1. The licensee failed to protect resident #002 from neglect by staff.

The following finding is related to Log # 003332-18:

For the purpose of the definition of "Neglect" in subsection 2(1) of the Act, Neglect is defined in
O.Regs 79/10 s. 5 as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

On a specified date, resident #002's Substitute Decision Maker (SDM) informed the Director of an incident of neglect via the Ministry Action Line. Resident #002 did not receive required care for a significant length of time resulting in resident 002's pain, distress and potential physical injury. Upon discovery of the neglect the Registered Nurse (RN) was alerted and an assessment was conducted. The RN expressed concern regarding the resident's discomfort possible trauma in a summary of the incident. The DOC received the summary a specified period of time later.

Resident #002's care plan at the time of the incident indicated that total assistance was required for specified care.

Assistant Director of Care (ADOC) #104 explained that management was informed of the incident on a specified date. The ADOC indicated that the incident was not reported to the Director or the SDM, but an internal investigation was started. The investigation conducted by the licensee confirmed that Personal Support Worker (PSW)s #106 & #107 had failed to provide required care. The incident was not reported immediately to the Director or the SDM nor was it reported immediately internally, contrary to legislation and licensee policy. The SDM was alerted via telephone call from ADOC #104 a specified period of time later. The licensee did not report the incident to the Director. No action was taken to protect residents from being neglected by PSW #106 and #107 as both PSWs continued to work directly with residents, thus, the licensee failed to comply with:
1. Duty to protect – LTCA s. 19. (1) The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by staff. 2007, c. 8, s. 19 (1). (refer to WN #001)
2. Plan of Care - LTCA s. 6. (9). The licensee shall ensure that the following are documented: The provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care, and the effectiveness of the plan of care. 2007, c. 8, s. 6 (9). (refer to WN #002)
3. Policy to promote zero tolerance - LTCA 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) (refer to WN #003)
4. Licensee must investigate, respond and act – LTCA s. 23. (1) Every licensee of a long-term care home shall ensure that, every alleged, suspected or

witnessed incident of the following that the licensee knows of, or that is reported to the licensee is immediately investigated, appropriate action is taken in response to every such incident and any requirements that are provided for in the regulations for investigating and responding are complied with. (refer to WN #004).
5. Reporting certain matters to Director – LTCA s. 24. (1) A person who has reasonable grounds to suspect that abuse and/ or neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. (refer to WN #005).
6. Notification re incidents – O. Reg. 79/10, s. 97 (1) (a) 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 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. (refer to WN #007).

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as the incident was isolated. The home had a level three history as they have had multiple non-compliances in similar areas:
• written notice (WN) issued November 2017_702197_0005 s. 20 policy to promote zero tolerance - Prevention of Abuse Neglect and retaliation.
• written notice (WN) issued September 2016 - 2016_280541_0021 s. 24 reporting to director - Prevention of Abuse Neglect and retaliation.
• written notice (WN) issued September 2015 - 2016_287548_0027 s. 24 reporting to director - Prevention of Abuse Neglect and retaliation.
• voluntary plan of correction (VPC) issued December 2015 (RQI) 2014_288549_0044 s. 20 policy to promote zero tolerance - Prevention of Abuse Neglect and Retaliation. (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 6 (9)., Documentation, specifically must ensure that the following:
1. The provision of the care set out in the plan of care for residents #007, #006 & #009 is documented, that is:
- assessment/treatments and related care for resident #007 and all other residents requiring assessments/treatments and related care
- bathing and nail care for resident #006 and all other residents, and
- specified care and safety monitoring for resident #009 and all other residents requiring specified care and safety monitoring
2. The outcomes of the care set out in the plan of care for resident #007 and all other residents requiring assessments/treatments and related care are documented.
3. The effectiveness of the plan of care for resident #007 and all other residents requiring assessments/treatments and related care
4. Review documentation expectations related to the provision of specified care and assessment/treatments with registered nursing staff and related care, bathing, nail care, and safety monitoring with all personal support staff; and
5. Implement for a 2 week period on every shift and on all nursing units, a monitoring process to ensure that documentation requirements related to the identified care areas are met;
6. Take immediate action when the absence of documentation is impeding the ability of nursing staff to validate and assess the effectiveness of the planned interventions; and
7. Incorporate the lessons during the monitoring period into a written report to be submitted to the Licensee/Board, with a copy to MOHLTC by the compliance due date

Grounds / Motifs :

1. The licensee failed to ensure that the provision, outcome and effectiveness of specified assessments, treatments and specified care including bathing, nail care, and safety monitoring as set out in resident plans of care were documented.

A) Resident #007 was admitted to the home on a specified date. The resident required specified assessments, treatments and other related care.

A registered dietician note indicated that resident #007 had significant, multiple care needs. A physician's note indicated that resident #007's care must be monitored carefully. Resident #007's SDM advised inspector #602 that hospital

staff had expressed concern regarding poor care provided at the home.

The licensee's policy and procedure specific to specified assessments and treatments instructs registered nursing staff to initial treatment interventions on the Treatment Assessment Record (TAR) record. It further directs registered nursing staff to complete specified assessments.

A specified number of assessment tools were reviewed; assessments were not completed for Resident #007's on a specified number of days..

ADOC #120 was interviewed and it was agreed that a number of assessments and treatments respectively had not been documented. Four of the required assessments were not documented as well as five treatments. ADOC#120 acknowledged that due to missing documentation, there was no evidence to support that weekly assessments and multiple treatments set out in the plan of care were provided, nor was the outcome or effectiveness of the care documented.

B. Resident #007's care plan contains numerous interventions including specified care every two hours and frequent monitoring for injury.

A review of resident #007's flow sheets indicated that resident #007 was not provided with specified care on over sixty percent of shifts. ADOC #120 acknowledged that it is the home's expectation that staff follow the care plan, and that missing documentation disallowed confirmation that care was provided.

Several PSW staff were interviewed and each indicated that they were aware that completed care is to be documented on flow sheets. The PSW's acknowledged, that given the lack of documentation, they could not confirm that resident #007 had been cared for as directed in the care plan during a specified period. The DOC agreed, in a subsequent interview, that without documentation, care provision, outcome and effectiveness could not be confirmed

C. Resident 006's care plan indicates bathing is required twice a week with the physical assistance of one staff. The plan further requires that nail care is completed.

During an interview, ADOC #101 confirmed that their Nail Care policy #0401-03-18, required that cleanliness and proper trimming of nails are assessed daily during dressing and weekly on bath days, and that PSWs are to trim/care for fingernails and toenails during resident #006's bath.

On a specified date, the DOC #100 reviewed a specified number of resident #006's personal care flow sheets and acknowledged that there was no documentation specific to nail care for 95% of possible check boxes. Nail Care policy #0401-03-18 indicates nails are to be assessed once a day while washing a resident's hands or bathing and that they are to be trimmed minimally weekly with sign off on flow sheets. DOC #110 agreed both bathing and nail care sections were not signed off and acknowledged that management need to work with staff to improve documentation of the care provided.

D. As of a specified date, resident #009 had fallen a specified number of times in a specified period during which the resident resided in the home. The care plan indicated that resident #009 was to receive certain fall related interventions including specific care and safety monitoring. Three PSW staff were interviewed and each indicated their awareness that resident care should be provided as outlined in the plan of care as well as documented for monitoring and ensuring safety. Each PSW acknowledged that, given the lack of documentation, they could not confirm that resident #009's care and safety monitoring.

In an interview, DOC #100 indicated upon review of resident #009's flow sheets, that incomplete documentation did not allow confirmation that the provision, outcome and effectiveness of care and regular safety monitoring was completed during the time periods reviewed..

In an interview on a specified date, ADOC #120 acknowledged that it is the expectation of staff to follow the care plan. It was explained that if someone is to be provided specific care and certain safety measures are to be in place then the provision of care should be documented. The current documentation audit process was reviewed and multiple misses were noted to be ongoing, despite verbal and written warnings.

A review of resident 009's flow sheets indicated that each two week form had multiple periods where care provision was not documented. There were no staff initials indicating the care had been provided and safety measures were in place as per care plan during 80% of the time period prior to the fall. Care and

monitoring were not reliably being documented on the specified flow sheets.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 2 as the lack of evidence to support that the required care was provided was found in two of three residents reviewed. The home has a level three history due to multiple non compliances issued with respect to provision monitoring and documenting of resident care including:
• voluntary plan of correction (VPC) issued December 2017 (RQI) 2017_702197_0012 includes the provision, monitoring and documentation of nail care and repositioning.
• voluntary plan of correction (VPC) issued December 2017 (RQI) 2017_702197_0012 includes the provision, monitoring and documentation of skin and wound care
• voluntary plan of correction (VPC) issued November 2017_702197_0005 includes monitoring documentation related to nutrition and hydration
• Compliance Order (CO) issued September 2017 2017_664602_0025 includes monitoring documentation related to nutrition and hydration
• voluntary plan of correction (VPC) issued June 2017 2017_597655_0011 includes the provision, monitoring and documentation of skin and wound care
• voluntary plan of correction (VPC) issued December 2015 (RQI) 2015_287548_0027 includes monitoring and documentation related to restraints (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

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