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

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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
Jun 25, 2018	2018_617148_0016	008954-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive OTTAWA ON K1V 8N5

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

St. Patrick's Home
2865 Riverside Drive OTTAWA ON K1V 8N5

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

AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), JESSICA LAPENSEE (133), SUSAN LUI (178)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): May 7-11, 14-18, 22 and 24, 2018

The following inspections were conducted concurrently with this Resident Quality Inspection: twelve logs related to falls, one log related to medication; ten logs related to abuse and neglect; three logs related to infection control; three complaints related to the provision of care; a complaint related to housekeeping and responsive behaviours; and a complaint related to housekeeping, falls and abuse.

The RQI also included a follow up to section 15 of the Regulation 79/10 related to the use of bed rails in the home.

During the course of the inspection, the inspector(s) spoke with the home's President and Chief Executive Officer, Vice President (VP) of Nursing, Assistant VP of Nursing, Manager of Support Services, Human Resource Manager, Maintenance, Maintenance Lead Hand, Resident and Family Services Coordinator, Registered Dietitian, Registered Physiotherapist, Physiotherapist Assistants, Restorative Care Aide, Housekeeping aide, Housekeeping Lead Hand, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Aide, Family and Residents.

The inspectors reviewed resident health care records, documents related to the medication management system, resident and family council meeting minutes, policies and procedures as required and the licensee's investigation documents related to the above identified inspections. In addition, the inspectors toured resident care areas in the home and observed infection control practices, medication administration, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2017_625133_0019	148

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 :

The licensee has failed to ensure that residents are protected from abuse by anyone.

Specifically, the licensee has failed to ensure that resident #029 and resident #043 were protected from recurrent incidents of resident to resident abuse, whereby the residents were not re-assessed and the plan of care was not reviewed and revised when the care set out in the plan had not been effective.

In addition the licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains, at a minimum, the required contents as set out by section 20 (2) of the LTCHA and that staff complied with this policy (as described by WN #7). Further, the licensee failed to ensure that incidents of alleged abuse are reported as described by section 24 (1) of the LTCHA (as described by WN #3).

The licensee submitted five critical incident reports (CIRs) to the Director within a specified three month period, which describe alleged abuse between resident #029 and resident #043.

It addition to these reported incidents, two additional alleged incidents of abuse were discovered during the Inspector’s review of progress notes.

Resident #043 was admitted to the home with a diagnosis of dementia. The most recent Minimum Data Set (MDS) Assessment, described the resident’s cognition to include the inability to make decisions. Inspector #148 spoke with resident #043, whereby the resident was able to converse with the Inspector but was not oriented to time and space. During the interview, the resident expressed that the resident’s spouse was living at the home. The Inspector spoke with several staff including the VP of Nursing #111, registered nursing staff #120, #153 and #154 and PSWs #151 and #155, who all described that resident #043 had identified resident #029 as the spouse and does not recognize #029 as anyone else. Resident #029 was confirmed to not be the spouse of resident #043.

Inspector #148 spoke with resident #029. Resident #029 was able to identify resident #043 and described resident #043 as someone that resident #029 enjoyed spending time with. In discussion, resident #029 expressed awareness that resident #043 does not know who resident #029 is, and will sometimes identify resident #029 as the father of resident #043. The Inspector spoke with several staff including the VP of Nursing #111, activity aide #158, registered nursing staff #120, 153 and 154 and PSWs #151 and #155, who all described that resident #029 has a level of understanding that resident #043 does not know the identity of resident #029. Further it was described by the VP of Nursing that resident #029 does not have the insight or judgment required for this type of

decision making and may forget that resident #043 is not able to consent to the described interactions and noted that resident #029 is also confused. Staff also reported that resident #029 becomes agitated when the residents are separated and will express curiosity as to the location of resident #043. The VP of Nursing expressed that resident #029 may have an increased in behaviours related to an identified medication administration, that at the time of the inspection had been discontinued. It was reported that previous to the incidents involving resident #043, there had been no incident of alleged abuse involving resident #029.

The plan of care for resident #043 in place at the time of the described incidents was reviewed. A plan of care item, titled behavior problem, related to the resident thinking co-resident is a spouse was added approximately two months after the incidents began. The interventions for this plan of care included that resident #043 believes a co-resident is a spouse and will initiate affection towards the co-resident; caregivers are to monitor closely; keep resident #043 distant from co-resident; and resident #043 has a sitter for a specified period every day for companionship and distraction. Staff members including PSW #151 and PSW/BSO #155 defined that "monitor closely" was to monitor the location of both residents #043 and #029. PSW #155 said that staff are to monitor throughout the shift and keep eyes and ears open. There was no documentation to support the provision of this plan of care intervention. As it relates to the provision of a sitter and or one to one, writer spoke with the VP of Nursing #111 who reported that resident #043 was provided with one to one services on two occasions. The plan of care was not updated to reflect the discontinued one to one until approximately one and a half months later. The plan of care for resident #043 also included an item for wandering. The interventions for this item included to keep the resident under staff vision at all times as the resident wanders into co-resident thinking that the resident is a spouse, keep both separated at all times. Staff interviewed did not indicate that resident #043 was under staff supervision at all times, staff described the resident as known to wander the unit and into resident rooms. As discovered through a review of the progress notes, resident #043 was observed during an evening shift, to have wandered into resident #046's room and was found to be undressed. The supervision of resident #043 at all times was not provided, as exampled by this occurrence.

The plan of care for resident #043 in place at the time of the described incidents was reviewed. A plan of care item, titled behavior problem, related to the co resident who believes resident #029 to be a spouse was added approximately two months after the incidents began. The interventions for this plan of care included to keep resident #029 occupied at a different location, away from co-resident and to remind resident #029 that

the co-resident thinks that resident #029 is a spouse. As of May 24, 2018 no further revisions have been made to this plan of care. In an interview with BSO/PSW #155, it was reported that resident #029 had been spoken to by staff and family members and it was described that resident #029 is explained that resident #029 needs to say no to resident #043 and that resident #029 cannot allow resident #043 to believe that resident #029 is a spouse. PSW #151 reported that resident #029 accepts the attention by resident #043 and does not stop the interactions with resident #043; PSW #151 further reported that resident #029 has been better at distancing from resident #043 when resident #043 approaches. Further to this, a progress note indicated that the BSO/PSW #155 spoke with resident #029 about the friendship with resident #043, whereby resident #029 was encouraged to respect the boundaries of the friendship. In the progress note, BSO PSW #155, indicated the plan was to continue to monitor.

As it relates to the intervention to keep the resident occupied at a different location, away from co-resident, the Inspector spoke with Activity Aide staff #158 who had been responsible for the unit up until May 1, 2018. Staff #158 noted that both resident #043 and #029 are offered to join activities and that there is an attempt to take one and not the other but this does not always occur as resident #029 will want to go where resident #043 goes. If both attend the same activity they are sat away from each other, however, resident #029 does not like to be separated. In an interview with VP of Nursing #111, it was described that staff are to keep the residents separated, exampled by one resident in the dining room while the other is not and to encourage resident #029 to attend off unit activities.

As it relates to the reassessment of the plan of care for resident #043, a physician order dated approximately one month after the first described incident was written for geriatric psychiatric consult to assess cognition and ongoing behaviours with co-resident. A progress note, more than two months later, indicated that consent from the substitute decision maker of resident #043 was obtained for the geriatric psychiatric consult. Inspector #148 discussed the approximate two months between physician order and processing of the referral with the home's Assistant VP of Nursing #113. The Assistant VP of Nursing indicated that during the completion of high intensity needs documents, it was discovered that the physician order had not been processed; specifically the consult for geriatric psychiatric was not faxed to outreach. During the on-site inspection, the resident was assessed by outreach mental health whereby recommendations were made to initiate a new medication and refer resident #043 to Behavioural Support Ontario (BSO) for an individualized plan of care.

Through interview with PSW/BSO #155 and review of the record it was determined that the BSO team within the home had discussed the interactions between resident #043 and #029 with resident #029, as described above; however, the BSO did not assess resident #043 during the four months of ongoing incidents. In an interview with VP of Nursing #111, the VP of Nursing said that resident #043 should have been seen by the BSO team related to the described behaviours.

It was noted during the record review and interview with the VP of Nursing #111, that the substitute decision makers for both residents had been approached and offered internal room transfers. Both families of the residents have declined to move rooms.

The licensee has failed to protect both resident #029 and #043 from incident of recurring abuse as exampled by not ensuring that the residents are re-assessed and the plan of care was reviewed and revised when the care set out in the plan has not been effective. (Logs 003867-18, 003768-18, 005323-18)

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. 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 :

The licensee has failed to ensure that equipment is kept clean.

On the morning of May 8, 2018, Inspector # 573 observed:
-food debris and food stains on the left side of the seat cushion and on the left wheel of resident #006's wheelchair.
-food stains on the left side of resident #007's wheelchair frame.

On the afternoon of May 8, 2018, Inspector #178 observed:
-unidentified dried residue on the left and right sides of the seat cushion and on the left armrest of resident #006's wheelchair. Resident #006 was not in the wheelchair at the time.
-unidentified dried residue on the headrest and left side of the seat cushion, and dried liquid stain on the middle of the seat cushion in resident #007's wheelchair. Resident #007 was not in the wheelchair at the time.

On May 9, 2018, Inspector #178 observed:
- Resident #006 was seated in the wheelchair and two chunks of food debris, each approximately one centimetre square, were visible on the left brake mechanism. Unidentified dried residue was visible on the left arm rest post of the wheelchair. Crusted food debris was also observed on the left side of the wheelchair seat.
-Resident #007 was seated in the wheelchair and dried liquid stains were visible on the metal mechanisms of the left side of the wheelchair.

On May 11, 2018, Inspector #178 observed resident #006 seated in the wheelchair. The same chunks of food debris initially observed by Inspector #178 on May 9, 2018, remained on the left brake mechanism of resident #006's wheelchair.

On the morning of May 14, 2018, Inspector #178 observed resident #006 seated in the wheelchair. The same chunks of food debris initially observed on May 9, 2018, remained on the left brake mechanism of resident #006's wheelchair. Unidentified dried residue was also visible on the right side of the seat cushion of resident #006's wheelchair.

On the afternoon of May 14, 2018, the Assistant VP of Nursing accompanied Inspector #178 to observe the wheelchairs of resident #006 and resident #007. Neither resident was in their wheelchair at the time of the observation. The following was observed:
-Resident #006: dried food residue was observed on the left arm rest post of resident #006's wheelchair. Small chunks of food were observed on the left brake mechanism, and what appeared to be a quarter of a piece of toast was observed wedged between the seat cushion and the wheelchair frame on the left side of resident #006's wheelchair.
-Resident #007: unidentified dried residue was observed on the head rest, and what

appeared to be dried liquid stains were observed on the seat cushion. Dried food residue was observed on the left arm rest, left armrest post, and on the left side of the seat belt where it attaches to the wheelchair frame.
The Assistant VP of Nursing indicated to inspector #178 that these two wheelchairs were not sufficiently clean. The Assistant VP of Nursing indicated that each resident's wheelchair or walker receives a light cleaning weekly on the resident's bath day by the night staff, and this cleaning is documented on Point of Care (POC), the home's documentation software. If the chair is heavily soiled, it would be sent for a deeper cleaning which is done in the basement by maintenance staff in the evening. Spot cleaning is also expected to be done by the unit staff if a resident spills something on their wheelchair in between the weekly cleaning.

Review of resident #006's plan of care indicated that resident #006's wheelchair is to be cleaned each week on the resident's bath day. Review of resident #006's POC documentation indicated that in the past four weeks between April 22 and May 12, 2018, resident #006's wheelchair was cleaned once. On each of the other three weeks, it was documented that resident #006's wheelchair cleaning was "Not Applicable".

Review of resident #007's plan of care indicated that the resident's wheelchair is to be cleaned each week on the resident's bath day. Review of resident #007's POC documentation indicated that in the past four weeks between April 19 and May 10, 2018, the resident's wheelchair was not cleaned. Each week during that four week period, it was documented that resident #007's wheelchair cleaning was "Not Applicable".

Consequently, multiple observations, staff interviews and review of the two residents' heath care records indicated that the licensee failed to ensure that the wheelchairs for resident #006 and resident #007 were kept clean.

Additional Required Actions:

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

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).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with.

The licensee's policy to promote zero tolerance of abuse and neglect of residents was identified as the policy titled, Resident Abuse: Prevention, reporting and elimination, updated September 2017.

The policy describes that employees are to immediately report alleged, suspected or

known incidents of abuse or neglect to the President/CEO or designate in charge of the home.

During the health care record reviews of resident #043 and #029, the Inspector observed a progress note describing an incident of alleged abuse.

The progress note was written by RPN #120, who indicated that the RPN did not believe the incident was abuse. RPN #120 reported that it was likely the incident had not been reported to the supervisory staff member present at the time. Inspector #148 spoke with RN #156, who was the supervisory staff member available on February 16, 2018. RN #156 did not recall having received a report related to the incident described.

The VP of Nursing #111, confirmed that there was no record of the staff member reporting the incident to supervisory staff or to the Director.
(Logs 003867-18, 003768-18, 005323-18)

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains, at a minimum an explanation of the duty under section 24 to make mandatory reports.

The licensee's policy to promote zero tolerance of abuse and neglect of residents was identified as the policy titled, Resident Abuse: Prevention, reporting and elimination, updated September 2017.

Inspector #148 reviewed the policy and noted that the policy contains the following related to the explanation of section 24:
- On page 1 under the heading Policy, the policy directs that immediate report of abuse or neglect is to be made to the President/CEO or designate in charge of the home;

- On page 2, under the heading of Procedure, the policy directs that staff are responsible to immediately (report) the alleged, suspected or witnessed abuse to Charge Nurse in the home; and

- On page 2, under the heading The Charge RN, the policy directs the RN to immediately report any of the following situations, including abuse and neglect, to the MOHLTC (Director);.

The explanation contained within the policy does not include that a person who has reasonable grounds to suspect abuse or neglect of a resident shall immediately report the suspicion and the information upon which it is based to the Director.
(Logs 003867-18, 003768-18, 005323-18)

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 policy to promote zero tolerance of abuse and neglect of residents is complied with and contains at a minimum the requirements of section 20 (2) of the LTCHA, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that the abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

During the health care record reviews of resident #043 and #029, the Inspector observed a progress note describing an incident of alleged abuse.

Both RPN #153, who wrote the progress note, and RN #154 who was on shift, indicated to the Inspector that this incident was abuse. Both staff members were aware of the requirement for mandatory reporting and were not able to describe why this incident was not reported. The VP of Nursing #111, confirmed that there was no record of a report to the Director for this incident.

The licensee did not ensure that the incident between resident #043 and #029 was immediately reported to the Director.
(Logs 003867-18, 003768-18, 005323-18)

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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or 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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents.

Resident #034's health record was reviewed. The resident was admitted with dementia and requires assistance of staff for all activities of daily living, including transferring and ambulating.

Review of resident #034's health record indicated that on a specified date, the resident fell and sustained an injury while being physically assisted by a staff member. Review of the Post Fall Assessment indicated that resident #034 fell in the hallway in front of the resident's room after care when the PSW was about to leave the room. The resident, who was pulling on the PSW's hand, quickly leaned backwards and fell. Review of resident #034's progress notes indicated that after the fall, the resident was sent to hospital for assessment and treatment of the injury.

On May 16, 2018, Inspector #178 interviewed PSW #143 who was present during the described fall incident. PSW #143 indicated that after providing care to resident #034, the PSW was about to transfer the resident from the resident's room to the dining room when the fall incident occurred. PSW #143 was physically assisting the resident to walk and while holding onto the resident the PSW leaned down to reach an item on the floor, at which time the resident fell backwards. The PSW indicated that the PSW was unable to grab the resident to prevent the resident from falling.

As such, the licensee failed to ensure that PSW #143 used safe transferring technique when assisting resident #034 to transfer from the resident's room to the dining room. (Log #009123-18 and #021020-17)

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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.

As part of the RQI, the VP of Nursing provided a summary of the home’s medication incident reports for the most recent quarter. A medication incident report indicated that on a specified date in 2017, resident #031 was found wearing two medication patches. The incident report indicated that the resident did not have an order for the patches, and they had been applied to the resident in error.

On May 10, 2018, the VP of Nursing indicated to inspector #178 that the incident had been investigated and it was determined that resident #031 had not been prescribed the patches, and the patches had been applied to the resident in error. The VP of Nursing indicated that the nurse had failed to use two methods to verify the resident’s identity when administering the medication, and as a result applied the medication to the wrong resident. The VP of Nursing indicated that the patches were removed as soon as the error was identified, the resident was monitored and did not suffer apparent harm as a result of the medication error.

2. A medication incident report provided by the home’s VP of Nursing indicated that on a specified date, it was discovered that resident #033 was not provided an antiviral as ordered by the physician. The incident report indicated that the resident was to receive two tablets of the antiviral, three times daily for seven days. Three days after the scheduled last dose, it was discovered that eight tablets of the antiviral were remaining in the vial, indicating that the resident did not receive all the tablets as ordered by the physician. The incident report indicated that the medication history was reviewed, and it was discovered that the staff had signed indicating that the tablets had been administered as ordered. On May 10, 2018, the VP of Nursing indicated to Inspector #178 that the pharmacy provided the antiviral tablets in a vial, not in the pre-packaged medication strip with the rest of the resident #033’s medications. The VP of Nursing indicated that it was their conclusion that some of the staff did not administer the antiviral tablets as ordered by the physician. The VP of Nursing indicated that resident #033 did not suffer any apparent harm as a result of the medication error, and staff education was provided to prevent recurrence.

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 drugs area administered to residents in accordance with the directions for use by the prescriber, to be implemented voluntarily.

WN #7: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A complaint was submitted through the Action Line, indicating that treatment was not provided to resident #026 for a skin wound during a specified period of time.

The health care record for resident #026 was reviewed. A physician order of a specified date indicated the following treatment for the pressure ulcer on the right elbow: cleanse the wound with saline, cover with adaptive and foam, change twice a week and as needed. The treatment course was then modified approximately one and a half months

later to include silvercel due to the change in condition of the wound.

Treatment records and progress notes were reviewed which indicates that treatment and/or wound assessment was provided on six dates during a specified period of time. The treatment records in part, for another period of time, could not be located within the record by the Inspector or the Assistance VP of Nursing during the health care record review.

The provision of care related to the wound treatment of resident #026 was not documented as required.

A complaint was submitted through the Action Line, indicating that the provision of baths for resident #025 was of concern. Inspector #148 spoke with the resident who indicated that occasionally two baths a week are not provided; specifically noting that one a month may be missed. The resident's plan of care indicated for bathing to be offered twice weekly on evenings. The resident's flow sheets, whereby staff document the provision of bathing, were reviewed. During the months of February, March and April 2018, the documentation did not support that bathing was offered to the resident at least twice a week, with at least one missing entry per month. Inspector #148 spoke with evening shift PSW #131 and PSW #132 who said that the resident enjoys bathing but may refuse a bath if offered by an unfamiliar staff member, such as agency staff. On these occasions, PSW #131 noted that the resident will be assisted with bathing by a regular staff person.

Inspector #148 spoke with resident #027 and #028, who reside on the same unit as resident #025, regarding the provision of bathing each week; neither resident indicated concern with being provided bathing twice a week. The plan of care for both resident #027 and #028 indicated that each resident will be offered bathing twice a week. The flow sheets for resident #027 for the months of February, March and April 2018 were reviewed. The documentation did not support that bathing was offered to the resident at least twice a week, with at least four missing entries per month. Resident #027 is scheduled for bathing during the day; day shift PSW #109 said that resident #027 does refuse bathing as it relates to mood and behaviours.

The flow sheets for resident #028 for the months of February, March and April 2018 were reviewed. The documentation did not support that bathing was offered to the resident at least twice a week, with at least four missing entries per month. The Inspector spoke with PSW #109 who said that this resident enjoys bathing and is not known to refuse such care. PSW #109 indicated that resident #028 would express displeasure if bathing was

not provided. PSW #109 acknowledged that there are times when staff are not able to complete all required documentation.

The provision of care related to bathing for residents #025, #027 and #028 are not documented as required.

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six month and at any other time when care set out in the plan of care has not been effective.

Specifically, the licensee has failed to ensure that resident #029 and resident #043 were protected from recurrent incidents of resident to resident abuse, whereby the residents were not re-assessed and the plan of care was not reviewed and revised when the care set out in the plan had not been effective.

In addition the licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains, at a minimum, the required contents as set out by section 20 (2) of the LTCHA and that staff complied with this policy (as described by WN #7). Further, the licensee failed to ensure that incidents of alleged abuse are reported as described by section 24 (1) of the LTCHA (as described by WN #3).

The licensee submitted five critical incident reports (CIRs) to the Director within a specified three month period, which describe alleged abuse between resident #029 and resident #043.

It addition to these reported incidents, two additional alleged incidents of abuse were discovered during the Inspector's review of progress notes.

Resident #043 was admitted to the home with a diagnosis of dementia. The most recent Minimum Data Set (MDS) Assessment, described the resident's cognition to include the inability to make decisions. Inspector #148 spoke with resident #043, whereby the resident was able to converse with the Inspector but was not oriented to time and space. During the interview, the resident expressed that the resident's spouse was living at the home. The Inspector spoke with several staff including the VP of Nursing #111, registered nursing staff #120, #153 and #154 and PSWs #151 and #155, who all described that resident #043 had identified resident #029 as the spouse and does not recognize #029 as anyone else. Resident #029 was confirmed to not be the spouse of resident #043.

Inspector #148 spoke with resident #029. Resident #029 was able to identify resident #043 and described resident #043 as someone that resident #029 enjoyed spending time with. In discussion, resident #029 expressed awareness that resident #043 does not know who resident #029 is, and will sometimes identify resident #029 as the father of resident #043. The Inspector spoke with several staff including the VP of Nursing #111, activity aide #158, registered nursing staff #120, 153 and 154 and PSWs #151 and #155, who all described that resident #029 has a level of understanding that resident #043 does not know the identity of resident #029. Further it was described by the VP of Nursing that resident #029 does not have the insight or judgment required for this type of decision making and may forget that resident #043 is not able to consent to the described interactions and noted that resident #029 is also confused. Staff also reported that resident #029 becomes agitated when the residents are separated and will express curiosity as to the location of resident #043. The VP of Nursing expressed that resident #029 may have an increased in behaviours related to an identified medication administration, that at the time of the inspection had been discontinued. It was reported that previous to the incidents involving resident #043, there had been no incident of alleged abuse involving resident #029.

The plan of care for resident #043 in place at the time of the described incidents was reviewed. A plan of care item, titled behavior problem, related to the resident thinking co-resident is a spouse was added approximately two months after the incidents began. The interventions for this plan of care included that resident #043 believes a co-resident is a spouse and will initiate affection towards the co-resident; caregivers are to monitor closely; keep resident #043 distant from co-resident; and resident #043 has a sitter for a specified period every day for companionship and distraction. Staff members including PSW #151 and PSW/BSO #155 defined that “monitor closely” was to monitor the location of both residents #043 and #029. PSW #155 said that staff are to monitor throughout the shift and keep eyes and ears open. There was no documentation to support the provision of this plan of care intervention. As it relates to the provision of a sitter and or one to one, writer spoke with the VP of Nursing #111 who reported that resident #043 was provided with one to one services on two occasions. The plan of care was not updated to reflect the discontinued one to one until approximately one and a half months later. The plan of care for resident #043 also included an item for wandering. The interventions for this item included to keep the resident under staff vision at all times as the resident wanders into co-resident thinking that the resident is a spouse, keep both separated at all times. Staff interviewed did not indicate that resident #043 was under staff supervision at all times, staff described the resident as known to wander the unit

into resident rooms. As discovered through a review of the progress notes, resident #043 was observed during an evening shift, to have wandered into resident #046's room and was found to be undressed. The supervision of resident #043 at all times was not provided, as exampled by this occurrence.

The plan of care for resident #043 in place at the time of the described incidents was reviewed. A plan of care item, titled behavior problem, related to the co resident who believes resident #029 to be a spouse was added approximately two months after the incidents began. The interventions for this plan of care included to keep resident #029 occupied at a different location, away from co-resident and to remind resident #029 that the co-resident thinks that resident #029 is a spouse. As of May 24, 2018 no further revisions have been made to this plan of care. In an interview with BSO/PSW #155, it was reported that resident #029 had been spoken to by staff and family members and it was described that resident #029 is explained that resident #029 needs to say no to resident #043 and that resident #029 cannot allow resident #043 to believe that resident #029 is a spouse. PSW #151 reported that resident #029 accepts the attention by resident #043 and does not stop the interactions with resident #043; PSW #151 further reported that resident #029 has been better at distancing from resident #043 when resident #043 approaches. Further to this, a progress note indicated that the BSO/PSW #155 spoke with resident #029 about the friendship with resident #043, whereby resident #029 was encouraged to respect the boundaries of the friendship. In the progress note, BSO PSW #155, indicated the plan was to continue to monitor.

As it relates to the intervention to keep the resident occupied at a different location, away from co-resident, the Inspector spoke with Activity Aide staff #158 who had been responsible for the unit up until May 1, 2018. Staff #158 noted that both resident #043 and #029 are offered to join activities and that there is an attempt to take one and not the other but this does not always occur as resident #029 will want to go where resident #043 goes. If both attend the same activity they are sat away from each other, however, resident #029 does not like to be separated. In an interview with VP of Nursing #111, it was described that staff are to keep the residents separated, exampled by one resident in the dining room while the other is not and to encourage resident #029 to attend off unit activities.

As it relates to the reassessment of the plan of care for resident #043, a physician order dated approximately one month after the first described incident was written for geriatric psychiatric consult to assess cognition and ongoing behaviours with co-resident. A progress note, more than two months later, indicated that consent from the substitute

decision maker of resident #043 was obtained for the geriatric psychiatric consult. Inspector #148 discussed the approximate two months between physician order and processing of the referral with the home's Assistant VP of Nursing #113. The Assistant VP of Nursing indicated that during the completion of high intensity needs documents, it was discovered that the physician order had not been processed; specifically the consult for geriatric psychiatric was not faxed to outreach. During the on-site inspection, the resident was assessed by outreach mental health whereby recommendations were made to initiate a new medication and refer resident #043 to Behavioural Support Ontario (BSO) for an individualized plan of care.

Through interview with PSW/BSO #155 and review of the record it was determined that the BSO team within the home had discussed the interactions between resident #043 and #029 with resident #029, as described above; however, the BSO did not assess resident #043 during the four months of ongoing incidents. In an interview with VP of Nursing #111, the VP of Nursing said that resident #043 should have been seen by the BSO team related to the described behaviours.

It was noted during the record review and interview with the VP of Nursing #111, that the substitute decision makers for both residents had been approached and offered internal room transfers. Both families of the residents have declined to move rooms.

The licensee has failed ensure that the residents are re-assessed and the plan of care was reviewed and revised when the care set out in the plan has not been effective. (Logs 003867-18, 003768-18, 005323-18)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

The licensee has failed to ensure that each resident is offered a minimum of a between meal beverage and a snack in the afternoon.

On a specified date, resident #030's substitute decision maker (SDM) submitted a complaint letter to the home related to resident #030 not receiving between meal beverages and snacks. The licensee's response letter to the complainant was an apology and indicated that staff will be reminded to offer resident #030 with beverages and snacks as per the home's scheduled nourishment passes. Further, the response letter identified that the resident's care plan was updated with the information.

According to resident #030's unit, the posted schedule time for afternoon snack pass was daily at 1400 hours.

On May 14 and 15, 2018, Inspector #573 observed the afternoon meal beverage and snack pass on resident #030's unit. On both the days, inspector observed that beverages and snacks were not offered to resident #030 in the afternoon.

On May 15, 2018, at approximately 1432 hours, Inspector #573 spoke with resident #030 who indicated that PSW staff had not offered the afternoon beverage and would like to have a glass of water and cranberry juice to drink.

On May 15, 2018, PSW #118 was interviewed and told the Inspector that they were responsible for the afternoon beverage and snack pass. PSW #118 indicated that the afternoon beverage and snacks was not offered to resident #030.

On May 15, 2018, Inspector #573 spoke with RN #142 who indicated that the PSW staff were to offer beverages and a snack in the afternoon during nourishment pass to resident #030.
(Log #003901-18)

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a communicable disease as defined in the Health Protection and Promotion Act.

During this Inspection, Inspector #573 reviewed three Critical Incident Reports (CIR) that were submitted by the licensee to inform the Director of an outbreak of a communicable disease. The CIRs are as follows:
January 17, 2018, a CIR was submitted related to an outbreak of Acute Respiratory illness, which was declared by Ottawa Public Health on January 17, 2018;
March 2, 2018, CIR #C569-000015-18 was submitted related to an outbreak of Acute Respiratory illness, which was declared by Ottawa Public Health on February 20, 2018; and
May 9, 2018, CIR #C569-000031-18 was submitted related to an outbreak of Acute Respiratory illness, which was declared by Ottawa Public Health on April 05, 2018.

On May 9, 2018, Inspector #573 spoke with the VP of Nursing, who confirmed with the inspector that the Director was not immediately informed of the three outbreaks on the respective days that they were declared by the Ottawa Public Health.
(Logs #001994-18, #006625-18 and #009487-18)

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

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident’s response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented, including the person who applied the device and the time of application, every release of the device and all repositioning.

On May 8, 2018, Inspector #573 observed resident #007 sitting in a wheelchair with table top in place.

On May 8, 2018, Inspector #573 spoke with PSW #116 regarding the use of resident #007's wheelchair table top. PSW #116 indicated to the Inspector that the wheelchair table top was used as a restraint for resident #007's safety to prevent from falls.

A review of resident #007's written plan of care in place indicated the use of wheelchair table top as a restraint. Inspector #573 reviewed resident #007's health care records for restraint which included the Substitute Decision Maker's consent and a corresponding physician's order for the use of wheelchair table top as a restraint.

On May 9, 2018, Inspector #573 spoke with RPN #105 who indicated that the residents with restraints are monitored hourly by the PSW staff, who document in the electronic health care record (Point of Care), the release and repositioning of the resident every two hours for a restraint.

Inspector #573 reviewed the Point of Care (POC) documentation for resident #007 in the presence of RPN #105. Upon review, it was observed that there was no records to demonstrate the table top restraint application, release and repositioning of the resident every two hours by the PSW staff member.

On May 10, 2018, during an interview, RN #114 confirmed with Inspector #573 that the application, release of the table top restraint and repositioning of resident #007 was not documented in the POC.

WN #11: 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 :

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Inspector #178 conducted an observation of the narcotic drawer on Dublin House on May 9, 2018 with RPN #105. Inspector #178 observed multiple controlled medications inside the narcotic drawer. In addition to the controlled drugs, Inspector #178 observed non-drug related items to be present in the narcotic drawer including a stethoscope, a gold ring with a red stone, and a box of Phillips shaver heads.

RPN #105 indicated that only controlled drugs should be stored in the narcotic drawer. RPN #105 indicated that the stethoscope was being stored in the narcotic drawer so it would be available to registered nursing staff on all shifts and would not go missing, as had happened in the past. RPN #105 indicated that the shaver heads belonged to a resident who was deceased some time ago, and were being stored in the narcotic drawer in case the family wanted them. RPN #105 had no knowledge of who owned the gold ring or who had put it in the narcotic drawer.

On May 11, 2018, the Vice President of Nursing (VPN) indicated to Inspector #178 that only controlled medications should be stored in the narcotic drawers. The VPN indicated that occasionally staff will store money or a resident's valuables in the drawer overnight, but they should be delivered the next day to the Finance Department for safe storage, or to a resident's family to take home.

Issued on this 9th day of July, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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) : AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), JESSICA LAPENSEE (133), SUSAN LUI (178)

Inspection No. / No de l'inspection : 2018_617148_0016

Log No. / No de registre : 008954-18

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jun 25, 2018

Licensee / Titulaire de permis : St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive, OTTAWA, ON, K1V-8N5

LTC Home / Foyer de SLD : St. Patrick's Home
2865 Riverside Drive, OTTAWA, ON, K1V-8N5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Janet Morris

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To St. Patrick's Home of Ottawa Inc., 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 s.19 of the LTCHA.

Specifically, the licensee shall ensure:
1) Resident #043 is reassessed and the plan of care is reviewed and revised to include interventions to effectively manage the behaviours and protect the resident from abuse; and

2) Resident #029 is reassessed and the plan of care is reviewed and revised to protect the resident from abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

Specifically, the licensee has failed to ensure that resident #029 and resident #043 were protected from recurrent incidents of resident to resident abuse, whereby the residents were not re-assessed and the plan of care was not reviewed and revised when the care set out in the plan had not been effective.

In addition the licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains, at a minimum, the required contents as set out by section 20 (2) of the LTCHA and that staff complied with this policy (as described by WN #7). Further, the licensee failed to ensure that incidents of alleged abuse are reported as described by section 24 (1) of the LTCHA (as described by WN #3).

The licensee submitted five critical incident reports (CIRs) to the Director within

a specified three month period, which describe alleged abuse between resident #029 and resident #043.

It addition to these reported incidents, two additional alleged incidents of abuse were discovered during the Inspector's review of progress notes.

Resident #043 was admitted to the home with a diagnosis of dementia. The most recent Minimum Data Set (MDS) Assessment, described the resident's cognition to include the inability to make decisions. Inspector #148 spoke with resident #043, whereby the resident was able to converse with the Inspector but was not oriented to time and space. During the interview, the resident expressed that the resident's spouse was living at the home. The Inspector spoke with several staff including the VP of Nursing #111, registered nursing staff #120, #153 and #154 and PSWs #151 and #155, who all described that resident #043 had identified resident #029 as the spouse and does not recognize #029 as anyone else. Resident #029 was confirmed to not be the spouse of resident #043.

Inspector #148 spoke with resident #029. Resident #029 was able to identify resident #043 and described resident #043 as someone that resident #029 enjoyed spending time with. In discussion, resident #029 expressed awareness that resident #043 does not know who resident #029 is, and will sometimes identify resident #029 as the father of resident #043. The Inspector spoke with several staff including the VP of Nursing #111, activity aide #158, registered nursing staff #120, 153 and 154 and PSWs #151 and #155, who all described that resident #029 has a level of understanding that resident #043 does not know the identity of resident #029. Further it was described by the VP of Nursing that resident #029 does not have the insight or judgment required for this type of decision making and may forget that resident #043 is not able to consent to the described interactions and noted that resident #029 is also confused. Staff also reported that resident #029 becomes agitated when the residents are separated and will express curiosity as to the location of resident #043. The VP of Nursing expressed that resident #029 may have an increased in behaviours related to an identified medication administration, that at the time of the inspection had been discontinued. It was reported that previous to the incidents involving resident #043, there had been no incident of alleged abuse involving resident #029.

The plan of care for resident #043 in place at the time of the described incidents was reviewed. A plan of care item, titled behavior problem, related to the

resident thinking co-resident is a spouse was added approximately two months after the incidents began. The interventions for this plan of care included that resident #043 believes a co-resident is a spouse and will initiate affection towards the co-resident; caregivers are to monitor closely; keep resident #043 distant from co-resident; and resident #043 has a sitter for a specified period every day for companionship and distraction. Staff members including PSW #151 and PSW/BSO #155 defined that "monitor closely" was to monitor the location of both residents #043 and #029. PSW #155 said that staff are to monitor throughout the shift and keep eyes and ears open. There was no documentation to support the provision of this plan of care intervention. As it relates to the provision of a sitter and or one to one, writer spoke with the VP of Nursing #111 who reported that resident #043 was provided with one to one services on two occasions. The plan of care was not updated to reflect the discontinued one to one until approximately one and a half months later. The plan of care for resident #043 also included an item for wandering. The interventions for this item included to keep the resident under staff vision at all times as the resident wanders into co-resident thinking that the resident is a spouse, keep both separated at all times. Staff interviewed did not indicate that resident #043 was under staff supervision at all times, staff described the resident as known to wander the unit and into resident rooms. As discovered through a review of the progress notes, resident #043 was observed during an evening shift, to have wandered into resident #046's room and was found to be undressed. The supervision of resident #043 at all times was not provided, as exampled by this occurrence.

The plan of care for resident #043 in place at the time of the described incidents was reviewed. A plan of care item, titled behavior problem, related to the co resident who believes resident #029 to be a spouse was added approximately two months after the incidents began. The interventions for this plan of care included to keep resident #029 occupied at a different location, away from co-resident and to remind resident #029 that the co-resident thinks that resident #029 is a spouse. As of May 24, 2018 no further revisions have been made to this plan of care. In an interview with BSO/PSW #155, it was reported that resident #029 had been spoken to by staff and family members and it was described that resident #029 is explained that resident #029 needs to say no to resident #043 and that resident #029 cannot allow resident #043 to believe that resident #029 is a spouse. PSW #151 reported that resident #029 accepts the attention by resident #043 and does not stop the interactions with resident #043; PSW #151 further reported that resident #029 has been better at distancing from

resident #043 when resident #043 approaches. Further to this, a progress note indicated that the BSO/PSW #155 spoke with resident #029 about the friendship with resident #043, whereby resident #029 was encouraged to respect the boundaries of the friendship. In the progress note, BSO PSW #155, indicated the plan was to continue to monitor.

As it relates to the intervention to keep the resident occupied at a different location, away from co-resident, the Inspector spoke with Activity Aide staff #158 who had been responsible for the unit up until May 1, 2018. Staff #158 noted that both resident #043 and #029 are offered to join activities and that there is an attempt to take one and not the other but this does not always occur as resident #029 will want to go where resident #043 goes. If both attend the same activity they are sat away from each other, however, resident #029 does not like to be separated. In an interview with VP of Nursing #111, it was described that staff are to keep the residents separated, exampled by one resident in the dining room while the other is not and to encourage resident #029 to attend off unit activities.

As it relates to the reassessment of the plan of care for resident #043, a physician order dated approximately one month after the first described incident was written for geriatric psychiatric consult to assess cognition and ongoing behaviours with co-resident. A progress note, more than two months later, indicated that consent from the substitute decision maker of resident #043 was obtained for the geriatric psychiatric consult. Inspector #148 discussed the approximate two months between physician order and processing of the referral with the home's Assistant VP of Nursing #113. The Assistant VP of Nursing indicated that during the completion of high intensity needs documents, it was discovered that the physician order had not been processed; specifically the consult for geriatric psychiatric was not faxed to outreach. During the on-site inspection, the resident was assessed by outreach mental health whereby recommendations were made to initiate a new medication and refer resident #043 to Behavioural Support Ontario (BSO) for an individualized plan of care.

Through interview with PSW/BSO #155 and review of the record it was determined that the BSO team within the home had discussed the interactions between resident #043 and #029 with resident #029, as described above; however, the BSO did not assess resident #043 during the four months of ongoing incidents. In an interview with VP of Nursing #111, the VP of Nursing said that resident #043 should have been seen by the BSO team related to the

described behaviours.

It was noted during the record review and interview with the VP of Nursing #111, that the substitute decision makers for both residents had been approached and offered internal room transfers. Both families of the residents have declined to move rooms.

The licensee has failed to protect both resident #029 and #043 from incident of recurringl abuse as exampled by not ensuring that the residents are re-assessed and the plan of care was reviewed and revised when the care set out in the plan has not been effective.

The severity of this issue was determined to be a level 3 as there was actual risk of harm to the residents involved. The scope of the issue was a level 1, indicating an isolated scope, as the non-compliance relates to two residents. The compliance history is a level 2, as there was one or more unrelated non compliance identified in the last 36 months.

(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 24, 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 25th day of June, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

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