Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_618211_0019	014939-19, 015995-19	Complaint

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

JOELLE TAILLEFER (211)

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): July 23, 24, 25, 29, 30, 2019 and August 1, 2, 6, 7, 15, 2019.

The following logs were inspected:
- Intake #011984-19, intake #015995-19 and intake #014939-19 related to an allegation of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Office (CEO), Physician, Human Resources Manager, Vice President of Nursing and Clinical Services (VP), Assistant Vice President of Nursing and Clinical Services (AVP), Admission Clerk, Registered Dietician (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator, Personal Support Workers (PSWs), a Behavioral Supports Ontario/ Personal Support Worker (BSO), Coordinator Administrative Services and Communication, family members and a resident.

In addition, the Inspector reviewed residents' health care records and documents related to the home's investigations, several pictures, emails, Communication Binder for 1:1 Staff, Mandatory Training and the home's policies related to Skin and Wound Care, Responsive Behaviors, Prevention and Reporting of Resident Abuse and Neglect, Head and Injury Routine (HIR). The Inspector observed resident care environments, resident care, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
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.

10 WN(s)
9 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (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 has failed to ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

In an interview with resident #004's family member on an identified date, they revealed that the 1:1 staff member was sitting to far from resident #007 to be able to intervene if the resident demonstrated responsive behavior toward resident #004. They demonstrated that resident #007 was sitting at a specified area close to where resident

#004 was sitting.

Review of resident #007's plan of care on an identified date, indicated that the resident had exhibited responsive behaviors towards co-residents for three specified years and specific interventions were implemented.

Review of resident's binder titled "Communication Binder Meant for 1:1 staff member" on an identified date, indicated the resident's responsive behaviors, triggers and specific interventions.

On an identified date, Inspector #211 observed resident #007's behavioral board placed in a specific area, which indicated the resident's responsive behaviors, known triggers and the interventions.

In an interview with the President and Chief Executive Officer (CEO) on an identified date, stated that a binder was developed by the Behavioral Supports Ontario (BSO) to give guidance to the 1:1 staff member related to the best way to approach and monitor resident #007. The President and CEO indicated that the concern was to keep a balance between supervising and following resident #007.

In an interview with the Behavioral Supports Ontario (BSO) #142 on an identified date, stated that the nursing staff were aware of resident #007's behaviors before an identified date. The resident's behaviors were written on the board located in a specific area. BSO #142 revealed that the resident has been followed with a 1:1 staff member since returning from the leave of absence on an identified date. The 1:1 staff member was given a binder. The binder included the resident's behaviors, triggers, does and don't, interventions, most recent resident's plan of care and the hourly mapping sheets. The BSO agreed that the 1:1 staff member's binder, the resident's care plan and the behavioral board did not indicate that the resident needed to be followed and did not specify the distance that should be kept between the staff member and the resident. BSO #142 specified that the distance between the 1:1 staff member and the resident should be close enough to be able to intervene if the resident suddenly demonstrated responsive behaviors.

On an identified date at a specific time, Inspector #211 and BSO #142 went to the identified unit to observe the distance between resident #007 and the 1:1 staff member. Resident #007 was sitting in a chair against the wall beside one of the unit hallway. The 1:1 staff member was sitting on the other side of a table near the opposite wall of the

The BSO #142 confirmed that the distance between the resident's 1:1 staff member and resident #007 was too far away to be able to intervene if the resident was suddenly triggered.

The licensee has failed to ensure that resident #007's written plan of care sets out clear directions related to the acceptable distance between a staff and the resident to be able to intervene if the resident had a responsive behavior related to a trigger. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other
(a) In the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

On an identified date, the Ministry of Long-Term Care (MOLTC) received a Critical Incident Report (CIS) regarding an alleged abuse for resident #004. The CIS indicated that resident #004 was found with altered skin integrity around the resident's identified body area by PSW #116 on the same date that the CIS was sent to the MOLTC.

Review of resident #004's health care records indicated that the resident's altered skin integrity area was observed by a PSW #124 on the previous shift.

Review of resident #004's progress notes written by RPN #120 three days later, indicated that PSW #124 did not inform RPN #120 about resident #004's altered skin integrity on the specified date, because PSW #124 assumed it was already reported on the previous shift since it was so obvious.

In an interview with RN #102 on an identified date, stated that resident #004's altered skin integrity area was found during a specified time on an identified date by PSW #116. The resident's altered skin integrity was reported late to the RN on that day. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the home's binder titled "Communication Binder Meant for 1 on 1 Staff" indicated to ensure resident #007 is supervised at all times. If you require a break inform the Registered Practical Nurse on duty.

In an interview with resident #004's family members on an identified date, they indicated

that they came to the floor at a certain time and there was no 1:1 staff member supervising resident #007. The family members indicated that they were informed by the licensee that resident #007 would be supervised closely by a 1:1 staff member 24 hours a day and seven days a week.

In an interview with the 1:1 staff member #135 on this identified date, the 1:1 staff member confirmed that resident #007 was left alone and the other staff on the floor were not informed.

Interviews with PSWs #126 and #136 on this identified date, stated that the 1:1 staff member didn't tell them that resident #007 was left alone without supervision.

In an interview with RPN #137 on the identified date, stated that the 1:1 staff member didn't follow the instruction specified in the resident's plan of care by not informing the RPN on duty to supervise resident #007 while leaving the resident unattended. [s. 6. (7)]

4. Review of the home's binder titled "Communication Binder Meant for 1 on 1 Staff" indicated that one of the 1:1 staff member's responsibility was to complete the resident's behavior mapping sheet daily.

Review of resident #007's progress notes written on a specified date, indicated to start the behavioral mapping for one week and then to reassess.

Review of the resident's behavioral mapping sheets indicated that the 1:1 staff member didn't document for eight identified shifts from a specific times.

In an interview with the AVPN on an identified date, stated if the 1:1 staff member didn't document on resident #007's behavioral mapping or the communication sheets, then the 1:1 staff member didn't follow the resident plan of care. [s. 6. (7)]

5. The licensee has failed to 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.

Review of resident #007s' health care records had no documentation related to the near miss altercation with resident #008 that occurred on an identified date and there was no documentation in resident #009's health care records related to resident #007's

responsive behavior toward resident #009 on another date.

In an interview with the VP of Nursing and Clinical Services on an identified date, stated RPN #128 didn't document the near miss incident of resident #007 's responsive behavior toward resident #008 that occurred on an identified date during a specific shift. In addition, the VP stated that RPN #128 didn't documented in resident #009's health care record the altercation between residents #007 and #009 that occurred on another identified date.

RPN #128 failed to document in resident #009's health care records, the altercation incident between residents #007 and #009 that occurred on an identified date. Additionally, RPN #128 failed to document the potential altercation between residents #007 and #008 that occurred on another identified date. As a result, RPN #128 failed to set out the provision, the outcomes and the effectiveness of the residents' plan of care. [s. 6. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for resident #007 that sets out,
(c) clear directions to staff and others who provide direct care to resident #007, to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other
(a) In the assessment of resident #004 so that their assessments are integrated and are consistent with and complement each other,
to ensure that the care set out in the plan of care is provided to resident #007 as specified in the plan, and
to 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, to be implemented voluntarily.

WN #2: 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 that the home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

Review of the home policy I ADM G 10.03 titled "Prevention and Reporting of Resident Abuse and Neglect" on an identified date, indicated:

All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any alleged, suspected or know incident of abuse or neglect to the President/CEO or designate in charge of the home. If any employee or volunteer are witnesses or has knowledge of suspected abuse or neglect they are responsible to immediately report the alleged, suspected or witnessed abuse to the Charge Nurse in the home. All staff must report the incident to either the President/CEO or designate if the Charge Nurse does not take action in accordance with this procedure. The Charge RN/CEO will refer to the decision tree for reporting requirements.

The Charge RN will immediately report any allegations or suspicious of abuse, unlawful contact to the President/CEO during normal business hours or if not available the designate. After Hours contact the Manager on Call who will refer to the decision tree to determine reporting requirements. Immediately report as soon as possible and no later than on the same shift that the allegation, suspected or witnessed abuse has been said to have occurred.

Inform the Substitute Decision Maker, if applicable, immediately of the alleged abuse if the incident has caused harm, pain, or distress to the resident (all other incidents must be communicated within 12 hours) and the current status of the resident, assuring them of the resident's safety. Advise the Substitute Decision Maker that an investigation will be carried out immediately, and communication with them will remain open. Document the current resident status on the resident's record and complete a Critical Incident Report. If

resident to resident abuse, update both resident's clinical records. Update the care plan as appropriate, ensuring that direct care staff are made aware of current resident (s) status.

Immediately notify the Police of any alleged, suspected, or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence.

Review of resident #007's progress notes on an identified date, RPN #128 documented that the resident became agitated by co-resident #009. Resident #007 exhibited responsive behaviors to co-resident #009 twice and proceed to exhibited another responsive behavior on the resident's identified body area several times.

In an interview with RPN #128 on an identified date, stated that resident #007 exhibited responsive behavior toward co-resident #009. They were both sitting at the same identified area. Before the incident, resident #007 was agitated. RPN #128 was unaware of the circumstance between both residents before resident #007 exhibited responsive behavior toward resident #009. RPN #128 was concerned that resident #007 would injured resident #009 and intervened immediately. The RPN indicated that the RN in Charge was informed after the incident.

In an interview with VP of Nursing and Clinical Services on an identified date, there was no documentation in residents #009's progress notes related to the altercation incident that occurred on the identified date between residents #007 and resident #009. VPN stated after a discussion with RPN #128 on another identified date, the RPN reported that resident #009 had an identified reaction by resident #007's action.

In an interview with RN #145 on an identified date, stated that the staff didn't report an altercation incident on an identified date between residents #007 and resident #009. The RN stated that if resident #007 had voluntary exhibited the responsive behavior toward resident #009, the manager on call, the police, the family and the Ministry of Long-term Care would have been informed.

The licensee has failed to ensure that the home's written policy I ADM G 10.03 titled "Prevention and Reporting of Resident Abuse and Neglect" on an identified date was complied when there was an altercation incident on an identified date between residents #007 and #009. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg 79/10, s. 2. (1) (b), emotional abuse means any threatening or intimidating gestures, actions, behavior or remarks by a resident that causes alarm or fear to another resident where the resident performing the gesture, actions, behavior or remarks understands and appreciates their consequences.

Review of resident #007's progress notes on an identified date, RPN #128 documented that the resident became agitated by co-resident #009. Resident #007 exhibited a responsive behavior toward co-resident #009 twice and proceed to exhibit another responsive behavior on the resident's identified body area several times.

Review of resident's #009's progress notes written by RPN #128 as a late entry on an identified date for the incident that occurred on an identified date, indicated resident #009 was sitting quietly at a specific area, when resident #007 became agitated about an unknown cause and started exhibiting responsive behavior towards resident #009. Resident #007 exhibited a specific responsive behavior towards resident #009's identified body area several times. Resident #007 was moved to another area permanently and RN was notified.

In an interview with RPN #137 on an identified date, stated that resident #007 was able to understand the consequence of the actions since the RPN heard resident #007 telling residents to stop doing a specific conduct as this increased resident #007's responsive behaviors.

In an interview with RN #145 on an identified date, RN stated not being contacted related to resident #007's responsive behavior incident toward resident #009 that occurred on an identified date. RN #145 revealed when a resident voluntary exhibit a responsive behavior towards another resident, it was considered a form of abuse. RN #145 indicated that if the RN was informed of the incident on the identified date, an investigation should have been started. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected, witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, 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 :

1. The licensee has failed to ensure when a person has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicious and the information upon which it is based to the Director.

Review of resident #007's progress notes on an identified date, RPN #128 documented that the resident became agitated toward co-resident #009. Resident #007 exhibited a specific responsive behavior to co-resident #009 twice and proceed to exhibit another responsive behavior on the resident's identified body area several times.

In an interview with the AVP of Nursing and Clinical Services on an identified date, indicated that the incident when resident #007 exhibited the specific responsive behavior towards resident #009 on an identified date was not reported nor submitted to the Director. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure when a person has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicious 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 :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report (CIS) regarding an altered skin integrity that was observed by PSW #116 around resident #004's specified body area on the identified date.

Review of resident #004's plan of care on an identified date, indicated to transfer the resident with the assistance of two staff using a specific device.

Review of the licensee's investigation notes on an identified date by inspector #211 indicated that PSW #125 informed the Vice-President of Nursing and Clinical Services and the Manager of Human Resources that resident #004 was transferred with another kind of device without a second staff present. PSW #125 also indicated that the resident was transferred into a loaner equipment because they were unable to find the resident's own equipment.

In an interview with the Manager of Human Resources on an identified date, stated that PSW #125 didn't follow the resident's plan of care related to transfer. PSW #125 should have used the identified device with the assistance of two staff for safety measures. The Manager of Human Resources also indicated that during the investigation they were informed that the resident was positioned inappropriately in a loaner equipment.

The licensee has failed to ensure that resident #004 was transferred safely to the loan equipment with the proper device on an identified date. Furthermore, the resident was not properly positioned in the specific device since the loaner device was not adapted for the resident's needs. [s. 36.]

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when a resident exhibiting altered skin integrity, including skin break down, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report (CIS) regarding an alleged abuse for resident #004. An altered skin integrity was observed by PSW #116 around the resident's specified body area on an identified date.

Review of the home's policy titled "Skin and Wound Care" on an identified date, under the section "Identification of risk for impaired skin" indicated: Management of all altered skin integrity including pressure injuries, skin tears, stasis ulcers, diabetic ulcers, moisture associated dermatitis, bruises, surgical wounds, rashes;
8.To complete wound assessment by registered staff using Skin Wound Module Assessment Tool with photo in the Point Click Care (PCC).
The policy indicated that the Skin Wound Module Assessment Tool with a photo on an i-pod will be found under Assessment section of PCC resident chart.

Review of resident #004's health care records eight days after the altered skin integrity was found, indicated that the altered skin integrity to the resident's identified body area was observed by a PSW #124 during an identified date and shift.

During a revision of resident #004's progress notes and the Skin and Wound Evaluation-V6.0 with the Vice President (VP) of Nursing and Clinical Services on an identified date, the VP confirmed that the clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was not used for resident #004's altered skin integrity during the specified shift on the identified date. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure when a resident exhibiting altered skin integrity, including skin break down, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Review of resident #004's health care records on an identified date, indicated that an altered skin integrity of resident #004's specific body area was observed by a PSW #124 at the beginning of the specific shift on the identified date.

In an interview with the VP of Nursing and Clinical Services on an identified date, stated that resident #004 did not received an immediate treatment and interventions to reduce or relieve pain and promote healing until the altered skin integrity to the resident's specific body area was reported on an identified date. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report (CIS) regarding an alleged abuse for resident #004. An altered skin integrity was observed by PSW #116 around resident #004's specified body area on an identified date. The CIS indicated that resident #004's family members also expressed concerned related to the previous incidents on three different dates.

Review of resident #004's progress notes indicated the following:
-On an identified date, RPN #123 wrote that an altered skin integrity was found behind

the resident's specific area.
-One month later, RPN #105 wrote that an altered skin integrity was found to another specific body area. An assessment was completed.
-Approximately three months later, RN #106 wrote that multiple altered skin integrity with a specific color were noted on the resident to two different body areas. An assessment was completed for both areas and the multiple altered skin integrity were resolved seven days later.
-Nineteen days later, RPN #121 wrote during a specific shift a staff noticed an altered skin integrity on another body area on the resident, while doing care on an identified time and the resident was unable to explain what happened. A skin assessment was completed ten days later by RPN #122 and a weekly assessment was completed related to the altered skin integrity body area indicating that the area was improving. Sixteen days later, a weekly assessment was completed indicating that the area was resolved.
-On an identified date, RN #118 completed two skin and wound assessments with two different measurements related to the resident's altered skin integrity on a specific body area. Sixteen days later, the skin and wound assessments for the two altered skin integrity areas on the identified body area were resolved.
-On the same month from a different date during an identified shift, RN #119 wrote that resident #004 was found with an altered skin integrity on two specific body areas with an unknown cause. During the next shift, RN #117 wrote that the family expressed concerns about the altered skin integrity to the two identified body areas. The family member indicated that it was the third time that the resident was found with unknown origin of altered skin integrity. The family requested to have the police force called and have the resident sent to the hospital.
-The next day, the resident returned from the hospital with a diagnosis related to the specified body area and an identified medical test of the resident's body structures area did not revealed further injury. On the same date, the physician wrote that the resident has a specific altered health issue. The easy altered skin integrity likely due to mild trauma with underlying specific altered medical health problem.
-The next day, RPN #120 wrote that the writer spoke with the PSW working at the beginning of the specific shift on the identified date. The note indicated that the PSW didn't informed the RPN on that date because the PSW assumed that the altered skin integrity was already reported since it was so obvious.
-Eleven days later, RPN #120 wrote in the progress notes that resident #004's 1:1 staff member indicated that the resident' s altered skin integrity has extended more laterally that it had been presented at the beginning of the shift.

In an interview with RPN #105 on an identified date, indicated that resident #004

sustained an altered skin integrity to a specific body area on an identified date and this altered skin integrety was resolved one month later. RPN #105 revealed that a skin assessment was completed on the identified date, and a weekly skin assessment is usually monitored visually and not documented. RPN #105 stated that the color of the skin on the resident's two specific areas was found on an identified date. It was two days later, that the colored areas to the resident's two specific body areas were categorized has an altered skin integrity and a skin assessment was completed.

In an interview with PSW #116 on an identified date, stated that an altered skin integrity to the resident's identified body area was discovered during care on a specific time and date. PSW #116 revealed that the resident's identified altered skin integrity body area was not present the previous day. The PSW revealed that the resident's body is often found with altered skin integrity spot of a specific color.

In an interview with the VP of Nursing and Clinical Services on an identified date, revealed that a weekly skin assessment for a specified body area discovered on an identified date, was not completed for the three following weeks.

In an interview with the VP of Nursing and Clinical Services on another identified date, revealed that the weekly skin assessment for another area of the resident's body discovered on another date was not completed for a specific week. The VP of Nursing and Clinical Services confirmed that the weekly skin assessment for the resident's two altered skin integrity areas found on the resident's identified body area and discovered on an identified date, were not completed for the identified week.

In an interview with the VP of Nursing and Clinical Services on an identified date, stated that a weekly skin assessment for resident #004's altered skin integrity to the identified body area have not been completed for several weeks.

The licensee has failed to ensure that the weekly assessment for resident #004's multiple altered skin integrity were recorded and completed for identified dates as confirmed by the VP of Nursing and Clinical Services. [s. 50. (2) (b) (iv)]

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 when a resident exhibiting altered skin integrity, including skin break down, pressure ulcers, skin tears or wounds received
-a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment
-immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required
-the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #007 was admitted to the home on an identified date with multiple medical

health issues.

Review of the physician order written on an identified date, indicated to change the dose of a specific medication at a certain time. Resident #007's Medication Administration Record for the identified month, indicated that the dose of a specific medication was changed on an identified date. Twenty six days later, the physician order indicated to send the resident to an identified establishment due to the responsive behaviors.

Review of the discharge summary from the establishment on an identified date, indicated that resident #007 was admitted for specific days with a history of several weeks of responsive behaviors in Long-Term Care. Prior to the admission, the resident's identified medication was changed to decrease fall frequency. This resulted in changed of responsive behavior over the following weeks.

Review of resident #007's progress notes for several months, indicated the following:

-On an identified date, RPN #105 wrote when resident #007 was assisted to the room, the resident suddenly exhibited responsive behavior toward PSW #125 who was walking beside the resident.

-One month later, RPN #128 wrote that the resident became agitated by co-resident #009. Resident #007 exhibited responsive behavior towards co-resident twice and proceed to exhibit another responsive behavior on the resident's specific body area several times.

-At approximately several months later, RPN #123 wrote that resident #007 was having responsive behavior toward a PSW staff as they walked beside the resident. Later, the resident approached a resident's family member while exhibiting responsive behavior and the writer was able to intervene. The resident was assisted to sit in the common area, but resident was still exhibiting behaviors. Later during the identified shift, the resident stood up and mobilized quickly while exhibiting responsive behavior. The resident was exhibiting an identified responsive behavior and then the resident exhibited another identified responsive behavior towards RPN #123. The resident refused their medication, but an identified medication as needed (PRN) was administered at a specific time.

-Sixteen day later, resident #007's progress notes written by RN #117, indicated that resident #004's family member informed the RN that resident #007 tried to enter co-

resident's room and was exhibiting responsive behavior toward a family member. RN #117 wrote that resident #007 was demonstrating three different behaviors in a specific unit area. Resident #007 was sent to an identified establishment and returned several days later.

-In an interview with RPN #128 on an identified date, stated during a specific shift for one of the two indicated dates, resident #007 was trying to exit another unit while resident #008 was trying to get in the unit. Resident #008 expressed the intention of passing by to resident #007. Resident #007 exhibited a responsive behavior toward resident #008. RPN #128 indicated that there was no physical contact during the altercation since RPN #128 intervened.

In an interview with VP of Nursing and Clinical Services on an identified date, stated resident #007 was entering in and out from other residents' room on an identified date, during a specific shift, but not resident #004's room. The VP revealed that resident #007 was sent to a specified establishment on an identified date, because the resident had responsive behavior toward the staff. Resident #007's behaviors was unpredictable especially with an identified trigger.

In an interview with PSW #128 on an identified date, stated that resident #007 entered resident #004's room on identified date. Resident #007 had specific responsive behavior when entering resident #004's room. PSW #128 indicated that resident #007 shortly left resident #004's room. The PSW revealed that another incident occurred in the past when resident #007 was being assisted by two PSWs to their room during an identified shift. Suddenly, resident #007 started having a responsive behavior toward PSW #128 without any previous signs of agitation. PSW #128 stated that resident #007 was unpredictable and may have sudden responsive behaviors. Furthermore, PSW #128 stated that some previous incidents occurred between resident #007 and resident #009. An incident occurred when resident #009 exhibited a specific behavior toward resident #007. Resident #007 demonstrated responsive behavior toward resident #009 and an altercation incident could have occurred if they didn't intervene.

In an interview with PSW #126 on an identified date, stated that resident #007 did occasionally enter other residents' room. When resident #007 entered other rooms, it was to search for the bathroom and resident #007 was not touching anything placed in the other residents' room.

In an interview with RN #103 on an identified date, stated that resident #007 was

monitored by staff as the other residents on the specified unit before the 1:1 staff member started when the resident returned from the leave of absence on an identified date.

In an interview with the AVP of Nursing and Clinical Services on an identified date, stated the licensee didn't report the incident that occurred on an identified date, when resident #007 exhibited responsive behavior toward resident #009 since the algorithm of the decision three for two different kind of alleged abuse didn't qualify. A Risk Management nor a referral to the BSO was completed. The AVP revealed that they need to discuss with RPN #128 to clarify this past incident. The AVP revealed that management was not informed of the incident between resident #007 and RPN #123 that occurred on another identified date. A risk management and an employee incident report were not recorded for that date. The AVP indicated management was not informed of the near miss altercation between resident #007 and resident #008 that occurred during an identified week. Furthermore, there was no documentation in resident #007's health care records related to this incident. The AVP indicated that this incident will be follow-up with RPN #128. The AVP revealed that they need to talk with PSW#125 related to resident #007's responsive behavior incident toward an employee that occurred on another identified date.

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm by resident #007's behaviors, including responsive behaviors, and to minimize the risk of altercation and potentially harmful interactions between and among resident on two identified different dates. [s. 55. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM), 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 of neglect of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Review of resident #007's progress notes on an identified date, RPN #128 documented that the resident became agitated toward co-resident #009. Resident #007 exhibited responsive behavior toward co-resident #009 twice and proceeded to exhibit another responsive behavior on the resident's identified body area several times.

Review of resident's #009's progress notes written by RPN #128 six months later of the date of the incident occurred, indicated resident #009 was sitting quietly at an specific area of the identified unit, when resident #007 exhibited responsive behavior about an unknown cause and started exhibiting an identified behavior toward resident #009. Resident #007 exhibited another specified responsive behavior toward resident #009's identified body area several times.

In an interview with VP of Nursing and Clinical Services on an identified date, stated after a discussion with RPN #128 on an identified date, the RPN reported that resident #009 was disturbed by resident #007's action.

In an interview with RN #145 on an identified date, indicated when a resident voluntary exhibit a responsive behavior toward a resident, it will be considered to be alleged abuse and the families would be contacted.

The licensee has failed to ensure that residents #007 and #009's SDMs, if any and any other person specified by the resident, were notified immediately when RPN #141 had witnessed resident #007 exhibit responsive behavior toward resident #009 and causes resident #009's distress that could be detrimental to the resident's well-being. [s. 97. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker (SDM), 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 of neglect of the resident that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Review of resident #007's progress notes on an identified date, RPN #128 documented that the resident exhibit responsive behavior toward co-resident #009. Resident #007 exhibited responsive behavior toward co-resident #009 twice and proceed to exhibit another specified responsive behavior on the resident's identified body area several times.

In an interview with RPN #128 on an identified date, stated that resident #007 exhibited responsive behavior toward co-resident #009. They were both sitting at the same area. Before an identified time, resident #007 was already showing responsive behavior. RPN #128 was unaware of the circumstance between both residents that provoked resident #007's responsive behavior toward resident #009. RPN #128 was concerned that resident #007 would exhibit a specified responsive behavior toward resident #009, thus intervened immediately.

In an interview with RN #145 on an identified date, RN was not contacted related to the incident that occurred on an identified date between residents #007 toward resident #009. RN #145 revealed when a resident exhibit this specific responsive behavior toward another resident, it was considered a form of abuse. RN #145 revealed that some days resident #007 was able to recognize the consequence of their actions. RN #125 indicated that if the RN was informed of the incident on that identified date and resident #007 action was voluntary, the police force would have been immediately contacted. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure the policy is complied with.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report (CIS) regarding an alleged abuse for resident #004. An altered skin integrity was observed by PSW #116 around the resident's specific body area on an identified date.

The resident's health care record indicated that the resident was transferred to the hospital on an identified date.

Review of home's policy titled "Head Injury Routine (HIR)" on an identified date, indicated all employees will report all incidents of a resident injury and/or change in neurological status immediately to the Registered Nurse in charge. The HIR need to be completed every 15 minutes for an hour, then as followed:
Every 30 minutes for two hours,
Every hour for four hours,
Every two hours for eight hours and,
Every four hours for 12 hours or until directed by the physician to cease monitoring.

Review of resident #004's HIR sheet indicated that the head injury assessment was taken and recorded on an identified date.

Review of the home's investigation with PSW #116 on an identified date, indicated that the PSW found the resident with an altered skin integrity on a specific body area on an identified date, between two specific times.

In an interview with PSW #124 on an identified date, stated that the resident's altered skin integrity body area was seen on an specific time on an identified date. PSW #124 revealed that the altered skin integrity was obvious and assumed that it was already reported and as a result the nurse was not informed. The PSW indicated that the first impression seeing the resident's altered skin integrity body area was that the resident may had a fall.

In an interview with the Assistant Vice President (AVP) Of Nursing and Clinical Services on an identified date, stated if PSW #124 had informed the nurse on the identified date when the resident's altered skin integrity body area was discovered, the bruise would have been assessed as an un-witness head injury and it would have been prudent to start an HIR. The AVP revealed that the first time the nurse documented the HIR was during the next shift on a specific time.

The AVP confirmed that the nurses did not maintain the HIR's frequency as indicated in the home's HIR policy from the time the altered skin integrity was discovered and reported until the resident was sent to the hospital on the next day at a certain time. [s. 8. (1) (b)]

Issued on this 16th day of September, 2019

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

Original report signed by the inspector.