Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 21, 2016	2016_251512_0011	019818-16	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26 Midhurst ON L0L 1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET COLLINGWOOD ON L9Y 4X1

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

TILDA HUI (512), GORDANA KRSTEVSKA (600), IVY LAM (646), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22, 26, and 27, 2016.

The following complaints were inspected concurrently with this inspection: 016011 -15 & 022838-15 related to personal care.

The following critical incidents were inspected concurrently with this inspection:

009404-14 & 017784-16 related to improper care; 005892-15, 010326-15 & 004016-16 related to verbal abuse; 017285-15 & 014178-16 related to neglect; 019316-15 related to verbal/emotional abuse; 024859-15, 017729-16, 018063-16 & 019906-16 related to falls; 008133-16 related to dining and snack services; 009875-16, 012312-16 & 020846-16 related to responsive behavior; 011207-16 related to continence care; 012890-16 related to plan of care; 014746-16 related to sexual abuse; 015747-16 related to elopement; 018407-16 related to medication management.
The following critical incidents were inspected concurrently with this inspection: 009404-14 & 017784-16 related to improper care, 005892-15, 010326-15 & 004016-16 related to verbal abuse, 017285-15 & 014178-16 related to neglect, 019316-15 related to verbal/emotional abuse, 024859-15, 017729-16, 018063-16 & 019906-16 related to falls, 008133-16 related to dining and snack services, 009875-16, 012312-16 & 020846-16 related to responsive behavior, 011207-16 related to continence care, 012890-16 related to plan of care, 014746-16 related to sexual abuse, 015747-16 related to elopement, 018407-16 related to medication management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Nurse Manager (NM), Food Services Supervisor (FSS), Nurse Practitioner (NP), Quality & Development Coordinator, Corporate Education Coordinator, Environmental Services Supervisor (ESS), Recreation Programs Supervisor, Registered Dietitian (RD), Registered Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Program Support Services Staff (PSS), Laundry Aide, Activationist Aide (AA), Residents, Family Members, Power of Attorneys (POA), and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **13 WN(s)**
- **5 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Section 2 (1) of the Regulation defines the following types of abuse:
"Emotional Abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization by anyone other than a resident.

Review of an identified Critical Incident (CI) report revealed on an identified date during an identified meal service, resident #010 was emotionally abused by Dietary Aide (DA) #153. DA #153 ignored the resident when the resident asked for a bigger spoon. DA #153 was overheard saying inappropriate comments to the resident relating to payment of services in the home. Then the DA turned to RN #149, who was present in the dining room, rolled his/her eyes and said another inappropriate comment about the resident. DA #153 admitted to RN #149 he/she had always ignored this resident.

Interview with RN #149 indicated the DA had been ignorant and had been intimidating resident #010 during the meal service.

Interview with Nurse Manager (NM) #124 confirmed RN #149 had witnessed the interaction between DA #153 and the resident, and that the home had investigated the incident immediately. The dietary staff had been sent on working leave pending investigation and then he/she had been on sick leave. DA #153 had not come back to work in the home. Further the NM confirmed the home expects the residents to be treated with respect and protected from any kind of abuse and resident #010 was not protected from abuse by DA #153. [s. 19. (1)]

2. In accordance with the definition identified in section 2(1) of the Regulation 79/10, "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self-worth, that is made by anyone other than a resident.

An identified CI report was submitted to the MOHLTC related to an alleged incident of staff to resident verbal abuse that had occurred on an identified date.

Record review of the most recent written plan of care revealed that resident #024 required two staff assistance with transfers and toileting care needs.

Review of the CI report revealed PSWs #127 and #133 were applying a transfer sling

under resident #024 while he/she was seated in a wheelchair. PSW #133 indicated the resident was giving PSW #127 dirty looks and PSW #127 responded by verbalizing inappropriate comments with profanity.

Interview with PSW #133 indicated he/she reported the incident to the RPN on duty who reported the incident to the RN in-charge. PSW #133 further revealed that he/she had been asked to provide a written statement of what he/she had observed and overheard.

Record review of the home's investigation notes revealed resident #024 had acknowledged that PSW #127 had used profanity on that day, but that he/she had already forgotten about it.

Interview with PSW #127 revealed that it had been possible he/she could have used profanity with resident #024 on the identified date that the incident occurred.

The home's internal investigation notes revealed that PSW #127 had been issued a discipline related to inappropriate language and conduct that had occurred on the above mentioned date.

Record review of PSW #127's personnel file revealed a previous discipline had been issued for inappropriate language and conduct that had occurred six months prior to the above mentioned incident.

Interview with NM #124 confirmed that resident #024 had not been protected from verbal abuse. [s. 19. (1)]

3. For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means, subject to subsection (2), the use of physical force by anyone other than a resident that causes physical injury or pain.

Review of an identified CI report submitted by the home on an identified date, revealed that PSW #125 had been abusive towards resident #031 while providing morning care in the resident’s room.

Interview with RPN #126 revealed on an identified date, as the RPN was leaving the medication room with the cart to administer medication, the RPN overheard a loud voice coming out of resident #031’s room, using inappropriate language apparently directed at the resident. The RPN recognized the voice as one of the PSWs on duty. RPN #126

stated that he/she walked in the room and told PSW #125 that the language he/she used was not appropriate, and his/her voice was too loud. The RPN continued to administer medication to residents down the hall.

Interview with PSW #127 indicated seven days prior to the identified date of the incident, he/she had been providing care to resident #031's roommate in the room. While in the same room, PSW #127 overheard PSW #125 yelling and screaming at resident #031 using profane words and threats. PSW #125 had not been able to get the shirt off the resident because one sleeve was trapped half way on the resident's arm. PSW #125 had been trying to get the shirt off the resident by pulling the resident's hand. Resident had an identified limitation in range of motion of his/her upper limbs and was not able to relax when PSW pressured him/her to cooperate with care. PSW #127 stated the resident had been looking at PSW #125 straight in the eyes saying nothing, but PSW #125 was heard speaking to the resident using inappropriate, vulgar, and threatening languages. PSW #127 stated he/she could not stand how the resident was treated and asked PSW #125 to leave the resident. PSW #127 completed the rest of the care while trying to calm the resident as the resident was visibly upset.

A second interview with PSW #127 further indicated that on the identified incident date, he/she was providing care to resident #031's roommate. At the same time, PSW #125 was providing care to resident #031 and was heard yelling at the resident and was noted to be rough while providing care. At some point RPN #126 entered the room and told PSW #125 that he/she was too loud and was using inappropriate language, and that was not appropriate. PSW #127 reported both incidents to the Director of Care (DOC) six days after the identified date of the incident.

Interview with NM #124 confirmed the staff is expected to provide safe care to the resident and to protect residents from abuse and neglect. PSW #125 failed to comply with the home's expectation as well as with the MOH regulation. The home had suspended PSW #125 and offered him/her additional education prior to returning to work. However PSW #125 was no longer an employee of the home. [s. 19. (1)]

4. The licensee has failed to ensure that residents were free from neglect by staff in the home.

For the purposes of the Act and in subsection 5 of the Regulation, neglect is defined as: the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that

jeopardizes the health, safety or well-being of one or more residents.

Review of an identified critical incident report revealed a suspected neglect incident occurred on an identified date, that resident #012 and resident #013 were allegedly being left at the dining table following their identified meal service until one and a half hour after the meal service had ended without having their faces washed, their soiled clothing protectors removed, and not taken to their rooms for toileting. The POA for the two residents came to visit on the identified date and time, and found both residents still sitting at the dining table. The POA notified the Administrator the next day regarding his/her concerns. The home initiated an investigation and implemented remedial action including revision of the resident's written care plan, posting a note in the dining room to remind staff to remove the two residents as soon as they finished their meals from the dining table, clean their faces, remove their clothing protectors, and take them to their rooms for toileting. Following the investigation, PSW #140 was disciplined for not providing care as per the care plan and was removed from providing care to the residents.

Phone interview held with the family of the POA who had submitted a complaint letter dated two days before the incident date on behalf of the POA, to the home regarding a similar incident noted a day prior, when the two residents were observed still at the dining table one hour and 50 minutes after the meal service had ended.

Review of the investigation notes indicated the two residents had been experiencing medical conditions and were receiving medication to relieve the symptoms. Staff believed due to the medication causing drowsiness, the residents had been more drowsy and was often seen dozing off at the dining table. Staff did try to keep the resident awake for meals however were not successful at times. The residents would be left to eat by themselves until later than usual.

Interviews with PSWs #140, #141, and RPN #136 indicated the two residents often came out to meals late and were left to finish later than the other residents, but not as late as stated by the POA. RPN #136 stated that it was 30 minutes after the identified meal service had ended that the POA came to visit on the incident date. Interview with PSW #146 who was on duty on the incident date indicated he/she was assigned to provide care to the two residents on that day. PSW #146 indicated there were a lot of visitors on the incident date requesting staff's attention for their residents. PSW #146 described the day as "chaotic" and admitted that he/she had forgotten to double check if the two residents had finished their meals, removed from the dining table, was cleaned and

brought to their room for toileting. PSW #146 stated he/she always checked the residents on his/her assignment prior to completing his/her shift at an identified time, however, did not do so on the incident date.

Interview with the administrator confirmed that care was not provided to resident #012 and #013 and that the two residents were neglected by PSW #146 on the incident date. [s. 19. (1)]

5. Review of an identified CI report, revealed a complaint voiced by resident #006 that the resident had an incontinent episode of loose bowel movement and had been waiting for 40 minutes to get cleaned up on an identified date. The home initiated investigation upon receiving the complaint.

Interview with the resident indicated the resident was upset with having to wait long to be cleaned up when he/she rang the call bell on the identified date, just before shift change at 2 p.m. on the unit. PSW #165 responded to the resident's call and told him/her to wait until the shift change report was finished. The resident waited for 40 minutes and rang the call bell again. By that time, the resident was in a mess with loose bowel movement and required a complete bed bath to clean up. The resident indicated that he/she had experienced prior incidents of staff delaying to respond to his/her call for assistance especially during shift change report times. The resident was not able to recall details of prior experiences including time frames.

Interview with PSW #104, who was on evening shift and came on at 2 p.m., indicated the resident did experience large amount of loose bowel movement on the identified incident date. PSW #104 responded to the resident's second call bell and provided care to the resident 40 minutes after the resident had initially rang the call bell for assistance. PSW #165, who responded to the first call, was not able to be reached for interview. PSW #104 stated he/she did not receive a message from PSW #165 that the resident was waiting to be cleaned up after shift report was finished.

Review of the call bell report on the incident date, revealed the resident rang the call bell at 2:00 p.m. and the call was responded after 14 minutes. The resident rang the call bell again at 2:33 p.m. and was responded after eight minutes.

Interview with the administrator indicated the length of time the resident waited to be cleaned up on the identified date, was not acceptable and that resident #006 had been neglected by staff at the home.

The severity demonstrated above was actual harm/risk which was non compliance that resulted in an outcome that had negatively affected the resident's ability to achieve his/her highest functional status. The scope was isolated when one or the fewest number of residents were affected, which was five percent (5%) or less of the affected surveyed population. The home's compliance history was with one or more unrelated non-compliance in the last three years (two full years and current year). The judgement matrix resulted in quadrant G and the issuance of a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Review of an identified CI report submitted by the home on an identified date, described an incident of staff being verbally abusive towards resident #022 six days prior to the report date, which was witnessed by laundry staff #132. The CI report revealed the laundry staff overheard a staff member yelling at the resident using inappropriate language while providing morning care. Interview with laundry staff #132 confirmed he/she witnessed the incident on the incident date, but had not reported immediately because he/she was not sure who to report the incident to. After six days and discussion with other staff members, the laundry staff notified NM #124 describing the incident. The laundry staff acknowledged he/she had not followed the guidelines for mandatory reporting and stated he/she should have reported the incident immediately.

Interview with the NM confirmed the home's staff had been encouraged and trained that any witnessed or suspected abuse or neglect is to be reported immediately to the Director and also to the RN on duty so the home will take action to provide safety to the resident. [s. 24. (1)]

2. Review of an identified CI report submitted by the home on an identified date, described an incident where PSW #125 had been verbally abusive towards resident #031 while providing morning care on the identified date and also six days prior to the identified date.

Interviews with PSW #127 revealed the PSW was the witness to the two above mentioned incidents at which PSW #125 was verbally abusive and rough when providing care to resident #031. PSW #127 indicated he/she did not report the first incident to anyone after he/she heard PSW #125 yelling at the resident while PSW #127 was providing care to the roommate.

Interview with RPN #126 revealed on the second incident date, as he/she had been leaving the medication room with the cart to administer medication, he/she had overheard a voice coming out of resident #031's room, using inappropriate language directed at the resident. The RPN recognized the voice as one of the PSWs, walked in the room and told PSW #125 that the language he/she used was not appropriate. The RPN then continued to administer medication to residents down the hall.

PSW #127 reported both incidents to the NM on the identified date, and a report was made to the MOHLTC.

Interview with RPN #126 confirmed he/she had not reported the second incident to the RN on duty or to anyone else. The RPN confirmed he/she had not identified the incident as verbal abuse to the resident at the time and therefore did not report it.

Interview with NM #124 confirmed the staff was expected to notify the manager on duty or call the action line number immediately after witnessing or suspecting abuse of the resident, however the staff had been also advised to notify the manager on duty immediately so the home will take immediate action to prevent further abuse and keep the residents safe. [s. 24. (1)]

3. Review of an identified CI report revealed an alleged staff to resident abuse/neglect which occurred on an identified date and time. Resident #015 was found with no pants on and dry feces on his/her legs and was not cleaned up and dressed until two and a half hours later. The incident was reported to the Nurse Manager on the same day however the critical incident report was not submitted to the Director until 25 days later. There was no indication that the home had notified the Director by using the after hours reporting phone line.

Interview with the NM #124 stated that the NM was unsure if this was a case of resident abuse and was planning to investigate to obtain more information before reporting to the Director. Interview with the Administrator confirmed that the suspected abuse/neglect incident should have been reported to the Director immediately as required by legislation. [s. 24. (1)]

4. Review of an identified CI report submitted to the MOHLTC on an identified date, revealed an incident of alleged staff to resident verbal abuse that had occurred one day before the identified date.

Interview with PSW #133 revealed he/she had witnessed PSW #127 using profanity while providing care to resident #024. PSW #133 further revealed he/she had been asked to provide a written version of the incident to NM #124 which had been completed on the identified date. PSW #133 revealed they have been instructed to follow the chain of command when reporting any alleged or witnessed incidents of abuse and/or neglect. PSW #133 revealed that the chain of command was as follows: report to RPN who reports to the RN who reports to the DOC or NM who reports to the Director.

Interview with NM #124 revealed that he/she had received an email on the identified date, one day after the incident of verbal abuse and confirmed that the incident of verbal

abuse had not been reported immediately to the Director.

The severity demonstrated above is actual harm/risk which is noncompliance related to the reporting of abuse and neglect of residents by the licensee and staff in the home that resulted in outcomes that had negatively affected the residents' ability to achieve their highest functional status. The scope is isolated when one or the fewest number of residents are affected, which is five percent (5%) or less of the affected surveyed population. The home's compliance history is with one or more noncompliance in similar areas in the last three years (two full years and current year). The judgment matrix resulted in quadrant G and the issuance of a compliance order is warranted. [s. 24. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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 there is a written plan of care for each resident that sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident.

An identified CI report related to the unexpected death of resident #041 was submitted to the Ministry of Health (MOH) on an identified date. Review of the Home's investigation notes and the physician's notes revealed cause of death to be an identified medical emergency condition, antecedent event/as a consequence of emesis.

Review of Home's investigation notes and interviews with staff revealed that on an identified incident date, resident #041 had breakfast, followed by a visit with his/her identified family members. After the family left, at around an identified time, PSW #152

heard the resident's wheelchair alarm from outside the resident's room and went in to investigate. PSW #152 saw the resident attempting to self-transfer from wheelchair onto the bed. PSW #152 assisted the resident to bed and turned the resident on his/her side due to an identified physical condition. The resident's bed was placed in low position and the identified safety device was activated. Approximately 45 minutes later, PSW #154 entered the resident's room and found the resident had vomited and was laying on his/her back. PSW #154 informed RPN #135 who then notified RN #143 by telephone. RN #139 was in the hallway and came in to assist.

RPN #135 and RN #139 attempted to perform an identified emergency resuscitation procedure on the resident. RN #143 arrived and seeing that RN #139 was performing the procedure, he/she went to check the resident's advanced directive and noted the resident had a Do Not Resuscitate (DNR) status. When RN #143 returned, the resident had stopped breathing and vital signs were absent. The physician was notified. Upon arrival, the physician determined the resident's cause of death was the identified medical emergency condition.

Record review of progress notes from five weeks prior to the incident date, revealed that the resident had a total of five separate incidents of emesis, four of which the resident was found in bed with emesis, and one episode where the resident coughed up phlegm while lying down after eating.

In the month prior to the incident date, the resident had a periodic cough and was monitored for other symptoms of infections, including emesis. Review of progress notes revealed that staff had elevated the head of the bed, and positioned the resident on his/her side on multiple occasions after an episode of vomiting.

Review of the written plan of care for resident #041 with an identified date revealed that interventions to minimize resident's risk of the identified emergency condition included assistance for eating, specific positioning, and remaining up after meals for 30 minutes.

Review of the written plan of care revealed there were no specific intervention related to nausea and vomiting for resident #041.

Interview with RN #139 revealed that, for residents with episodes of vomiting, close monitoring would be done. Interventions would include elevating the head of bed. RN #139 confirmed that intervention for positioning the resident in bed related to episodes of emesis or for risk of choking was not included in resident #041's most recent written plan

of care. RN #139 confirmed that the history of vomiting and risk of choking, along with the interventions, should have been in the resident's written plan of care.

RPN #135 confirmed the home's normal practice if vomiting occurred multiple times, a referral would be sent to the Registered Dietitian (RD) for an assessment. Per interview and record review, no referral was sent to the RD regarding resident's emesis within the above mentioned time period. RD #131 revealed that interventions for residents with regular episodes of vomiting would include eating smaller meals more often, encouraging fluids, sitting upright at meals and not laying residents back down for a set period of time after a meal. RD #131 revealed that he/she did not receive any referrals for the resident related to emesis.

Interview with NM #124 revealed that if the vomiting was an ongoing issue, then it should be noted in the resident's care plan for PSWs to see when providing care for resident, so that the registered staff and PSWs were aware. He/she confirmed that the interventions of elevating head of bed and placing resident to his/her side in bed, related to emesis and periodic cough with difficulty clearing phlegm, should have been put in resident #041's written plan of care.

Interview with the Administrator confirmed that the planned care for the resident was not included in the resident's written plan of care and clear directions were not provided to staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #026 collaborate with each other, 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.

An identified CI report was submitted to the MOH related to an incident of resident to resident sexual abuse that had occurred on an identified date.

Record review of a Behavioural Support System Mobile Support Team (BSS-MST) consult note dated 18 months prior to the incident date revealed that Activationist Aide (AA) #158 had been informed by resident #026's family that he/she had been through an identified traumatic life experience and as per the family's request this information had not been disclosed on the admission assessment.

Record review of the most recent written plan of care for resident #026 revealed three

identified responsive behaviours. Further review of the above mentioned consult note also revealed that resident's family wanted the long term care staff to know resident #026's life story but not to bring it up with him/her as it had been a traumatizing life event. The consult note further revealed that discussion between AA #158 and BSS-MST team member had been held related to the resident's identified responsive behaviours.

Interview with AA #158 revealed that the above mentioned had not been documented in his/her admission note as per family request and that the resident's life story had been relayed through word of mouth to staff working on resident #026's resident home area (RHA) at the time. AA #158 could not confirm if he/she had collaborated with others involved in the plan of care when resident #026 was transferred to a new RHA.

Interview with PSW #104 revealed that he/she had been informed of resident #026's life story by the resident's family member when transferred to his/her current RHA. PSW #104 further revealed he/she had not collaborated with the registered staff.

Interview with RPN # 121 revealed that he/she had not been aware of resident #026's life story and that staff and others involved in the different aspect of his/her care had not collaborated with him/her.

Interview with NM #124 confirmed that the staff and others involved in the different aspects of care of resident #026 had not collaborated with each other, in the development and implementation of the resident's plan of care so that the different aspects of care were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of resident #010's Minimum Data Set (MDS) assessment with an identified date, revealed the resident had been identified as frequently incontinent of urine. Resident #010's continence level had been described as deteriorated from the previous quarter when the resident was identified as occasionally incontinent of urine. Further review of the resident's Resident Assessment Protocol (RAP) in MDS revealed the staff had been aware of the increased number of incontinent episodes of the resident in the last quarter, however, the planning goal had been set to maintain the resident's current level and avoid complication.

Review of resident #010's chart and electronic documentation indicated a continence reassessment had not been completed since the deterioration.

Interview with RPN #107 confirmed resident #010 had not been reassessed for continence when his/her condition changed as the level of continence had been automatically triggered by the information the PSW entered in the point of care (POC) every shift.

Interview with the RN #106 confirmed the resident must be reassessed and plan of care reviewed and revised any time when the resident's continence level changed. [s. 6. (10) (b)]

4. Record review of an identified CI report revealed that resident #021 fell on an identified date and sustained a fractured right hip.

Record review of the physiotherapy (PT) referral post falls incident completed on the identified date, revealed that resident had an identified weight bearing status.

Record review of resident’s #021’s written plan of care with a review completion date of two months prior to this inspection, revealed under the transfer focus to provide two staff supervision, guidance and physical support for all transfers. The plan of care also outlined the resident's identified weight bearing status.

During the inspection period in resident #021's bathroom, the Inspector observed a transfer logo which depicted a mechanical lift.

Interview with PSW #104 revealed that the resident had been transferred with the aid of a mechanical lift with a two-person assist for quite some time now. Interview with RPN #108 revealed that the resident’s transfer requirement can be located in the resident’s written plan of care, the kardex in POC, and in resident’s bathroom where a transfer logo is posted on the mirror. RPN #108 further revealed that resident #021 had been transferred with a mechanical lift for quite some time now. RPN #108 indicated that resident #021's written plan of care had not been revised when his/her transfer care needs had changed from requiring manual to mechanical assistance.

Interview with NM #124 confirmed that resident #021's written plan of care had not been revised when his/her care needs changed. [s. 6. (10) (b)]

5. This inspection was triggered in stage 1 during the staff interview which revealed resident #005 had low BMI that was not addressed in the resident's written plan of care.

Record review of resident #005's progress notes for a period of 17 weeks revealed the resident has been regularly refusing to come to the dining room for meals. Further record review indicated the resident had days and nights mixed up and remained awake late into the evening. The resident was provided with nourishment overnight on 23 occasions over the identified period. Resident #005 also received tray service in room when he/she refused to come to the dining room for meals on 17 occasions over the identified period. Dietary progress notes on two identified dates indicated resident #005 preferred to stay in bed, refused to come to the dining room claiming he/she was not hungry but consumed some of meals when provided with a tray in room as per the care team, and that resident #005 needed to be encouraged constantly now to come to the dining room, respectively.

Review of resident #005's plan of care with an identified date, indicated that resident eats meals in the unit dining room and to place the resident at meals with residents who have similar interests. There were no interventions related to tray service, or of receiving snacks in the evening. Review of the resident's nutrition plan of care signed two months after the last review date indicated there were no changes to the plan of care. Further review of the most recent plan of care indicated the resident preferred to get up when wakened in late morning and would do his/her own care when wakened. It was indicated that the resident preferred to stay up very late into the night and will wander during most night shifts. The resident would require rest periods throughout the day. There were no interventions related to tray service, or of receiving snacks in the evening included in the written plan of care.

Observations made on three occasions during the inspection period in the morning, at lunch time, and in the afternoon revealed that the resident was asleep in his/her room.

Interview with PSW #107 revealed the resident was awake at lunch and received tray service in his/her room where he/she ate most of lunch and went back to sleep.

Interview with Dietary Aide (DA) #155 confirmed that the resident very seldom ate in the dining room, especially for breakfast and lunch meals, about once or twice per week. Interview with PSW #107 confirmed that resident #005 usually slept during the day, got up in the evening shift, and had some snacks at night. Resident was provided with trays

when he/she was awake at lunch but did not come to the dining room for meals, and that he/she was often in bed during breakfast and lunch meals. PSW #107 stated that resident #005 got up usually around dinner and ate in the dining room. PSW #107 confirmed that was not unusual for the resident.

Interview with Registered Dietitian (RD) #131 confirmed that he/she was aware that the resident ate over night and was not taking meals during the day at times. RD #131 stated that he/she was not aware that it was a consistent issue. The RD had assessed resident #005 five months prior to the inspection, and noted that the resident had his/her days and nights mixed up and there were days when resident #005 was not eating meals during the day but snacking overnight. RD #131 stated that the resident was having fair intake overall, and did not recommend any additional interventions and was not worried at the time. However, RD #131 confirmed that for residents regularly missing breakfast and lunch, it should be documented in the plan of care. And since resident was losing weight and not eating regularly in the dining room, RD #131 would want to provide something substantial on the off-time when resident did eat.

Interview with Dietary Supervisor (DS) #100 confirmed that either the DS or the RD could update the plan of care, and that if residents were receiving tray service on a repeated basis that it should be documented in the plan of care. DS #100 indicated he/she could not find any documentation in the plan of care concerning tray service, and confirmed that the plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

6. Review of an identified CI report submitted by the home on an identified date, revealed an incident in which the provision of incontinence care for resident #006 was delayed for 40 minutes.

Review of resident #006's assessment records on PCC revealed the resident was assessed to be continent of bowels on admission. Review of the minimum data set (MDS) dated after admission also described the resident as continent of bowel. However subsequent MDS at nine months and one year post admission, described the resident to be occasionally incontinent of bowel. The MDS assessment dated 14 months after admission described the resident as frequently incontinent of bowel. Review of the resident's current written care plan indicated the resident was continent of bowel.

Interview with PSW #101 and #104 indicated the resident was frequently incontinent of bowel. The resident continued to have some sensation of an urge and would ask to be

put on the bedpan at times. However most of the times, the resident would be incontinent and did not ask for the bedpan.

Interview with RPN #163 indicated the resident had deteriorated gradually over the last few years since admission. The resident was presently frequently incontinent of bowel. Interview with NM #124 confirmed that the resident's written care plan should have been revised to reflect the bowel incontinence status of the resident.

Interview with the Administrator confirmed that the home's expectation was for the resident's current written plan of care to be revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident, that the staff and others involved in the different aspects of care collaborate with each other, 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, and that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of an identified CI report revealed RPN #135 on an identified date, was completing end of shift narcotic count and discovered one vial of an identified narcotic medication missing from a box of five vials in the medication emergency stock box.

Interview with RN #106 who was the day nurse in charge revealed the practice in the home was for two staff to count the narcotics on each shift, so that the staff coming in count the actual medication in place and the outgoing staff was confirming the unit and individual narcotic sheet to match the numbers.

Interviews with RPNs #118 who was on evening shift on the day before the identified date, RPN #136, and RPN #137 who was on duty on the identified date, revealed when they did the narcotics count, they did not count the individual vial but count the box where the vials were.

Review of the home policy for narcotics counting stated the staff was expected to count each actual medication in their box on each shift and document the numbers.

Interview with NM #124 confirmed that the staff was expected to count the actual medication when they did the narcotic count, and during this incident, the staff had failed to comply with the home's policy as they were not counting the actual medication. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas were locked when they were not being supervised by staff.

Observation made during the inspection period on an identified unit noted the door to the soiled utility room was kept open with a wedge at the bottom of the door. There were two carts in the room with bags of soiled linen. A bedpan washer was noted in the room with a red light on and the cover opened. A key pad was noted on the door. A resident was observed sitting on a couch in the hallway directly across the hall from the soiled utility room.

The inspector stayed at the room for about five minutes and did not observe staff presence. The inspector then proceeded to look for staff on the unit. Interview with RPN #137 indicated the door to the soiled utility room was supposed to be kept closed and locked at all times. The RPN proceeded to close and lock the door.

Interview with the administrator confirmed that the door to the soiled utility room should be kept closed and locked at all times. [s. 9. (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 that doors leading to non-residential areas were locked when they were not being supervised by staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure behavioural triggers have been identified for the resident demonstrating responsive behaviours.

Three identified CI reports submitted to the MOHLTC revealed incidents of resident to resident responsive behaviours.

Record review of resident #026's health record revealed a consult note from the Behavioral Support Services - Mobile Support Team (BSS-MST) where AA #158 had been informed by resident #026's family member that he/she had been through an identified traumatic life experience and as per the family's request this information had not been disclosed on the admission assessment. Resident #026's family member wanted the long term care staff to know the resident's life story but did not want the staff to bring it up with him/her as it had been a traumatizing life event. The consult note further revealed that discussion between AA #158 and BSS-MST member had been held related to the resident's identified responsive behaviours. As well, the consult note revealed that all of the above mentioned responsive behaviours could be relating back to what resident #026 had endured during his/her identified traumatic life experience.

Record review of the most recent written plan of care revealed identified triggers to the resident's responsive behaviours. The plan of care had not addressed resident #026's past life story of having gone through the identified traumatic experience.

Interviews with RPN #121 and PSW #104 revealed that behavioural triggers related to resident #026's past life story had not been identified in the written plan of care to assist in managing his/her responsive behaviours.

Interview with NM #124 confirmed that behavioural triggers related to resident #026's past life story had not been identified in the written plan of care. [s. 53. (4) (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 behavioural triggers have been identified for the resident demonstrating responsive behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practises and, if there are none, with prevailing practises, for cleaning and disinfection of resident care equipment including shared transfer slings used for residents.

Observation made by the Inspector during the inspection period on an identified unit noted PSW #101 moving a mechanical lift with a sling on top out of an identified resident's room. Five minutes later the PSW was observed moving the same lift and the sling into another identified resident's room across the other hallway. There was another PSW in the room waiting to transfer resident in the second identified resident's room from the wheelchair to the bed. The Inspector did not observe the staff perform any cleaning or disinfection procedures on the transfer sling prior to being used on the resident in the second identified resident's room.

Interview with PSW #101 revealed there were altogether three mechanical lifts on the unit being used to transfer residents. The PSW stated there were 10 residents on the unit requiring mechanical lift for transfer. There were one to two slings attached with each lift for the 10 residents. The residents did not have their individual sling for use. The Inspector asked if there were any cleaning procedures used on the slings between residents' use. The PSW indicated that there was no established procedure to clean the sling in between use. If the slings were visibly soiled, they would be sent to laundry for washing. The PSW stated that all slings were sent to the laundry for washing at the end of each day.

A second Inspector interviewed PSWs #152, #154 and RN #139 indicated that there were no established procedure to clean and disinfect the transfer slings after being used on one resident and before being used on another resident. The second Inspector clarified with the local public health representative that the transfer slings were classified as personal care equipment and should be cleaned and disinfected in between shared uses.

Interview with the NM and the administrator confirmed there was no policy set up to address the issue and there were no instructions given to direct care staff to clean and disinfect the transfer slings in between residents' uses. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practises and, if there are none, with prevailing practises, for cleaning and disinfection of resident care equipment including shared transfer slings used for residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's drugs and treatments.

During stage one of the RQI inspection, resident #010 had been identified as having a low risk for incontinence in the MDS assessment conducted at an identified date.

Review of resident #010's MDS assessment dated three weeks after the identified date revealed the resident had been identified as frequently incontinent of urine and his/her continence level had deteriorated as compared with the MDS from the last quarter when resident had been identified as occasionally incontinent of urine. The MDS review also revealed the resident had been diagnosed of a medical condition with onset two months prior to the identified date, and had been receiving an identified medication. Further review of the MDS's resident assessment protocol (RAP) revealed the staff was aware of the increased number of incontinent episodes of the resident in that quarter, however, the planning goal was set to maintain the resident's current level and avoid complication.

Review of the resident's written plan of care revealed focus, goal and interventions were in place to address urinary incontinence of the resident. However, the written plan of care failed to reveal any action plan to address the effect of the identified medication on the resident's continence level.

Interview with RPN #107 confirm the resident's written plan of care did not address the resident's care needs with respect to the residents' medication that affects resident's continence. [s. 26. (3) 17.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review of the most recent MDS assessment's Continence Care and Bowel Management revealed resident #010 was triggered as a low risk for incontinence. Review of the resident chart and electronic documentation failed to reveal a completed assessment tool on resident's admission on an identified date or any time after the admission.

Interview with RN #106 revealed the practice in the home was for every resident to be assessed for continence on admission and when resident's conditions change that affect the continence. Interview with RPN #103 indicated that the initial continence assessment was done by the RN who was working on the admission process and collecting information from the families, CCAC or the records from the resident's previous place of living.

Interview with the RN #139 confirmed he/she was working on the admission process of the residents and collected information in order to create the 24 hour care plan for the resident, however the PSWs were to monitor the resident for seven days and complete the bladder and bowel elimination diary. Based on the information from the diary and the RPN's observation, the RPN should have completed the admission/comprehensive continence assessment, an electronic tool specifically designed for assessment of continence.

Interview with RN #106 confirmed resident #010 had not received a continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, conducted by using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. Review of resident #006's assessment records revealed the resident received a continence assessment using a clinically appropriate tool on admission on an identified date. The resident was assessed to be continent of bowels at the time. Review of the MDS dated four days prior to the identified date, also described the resident as continent of bowel. However subsequent MDS at nine months and a year post admission described the resident to be occasionally incontinent of bowel. MDS dated 14 months after admission described the resident as frequently incontinent of bowel. Record review did not reveal any evidence that a continent assessment using a clinically appropriate tool was conducted on the resident between nine to 14 months after admission, during this time period the resident's bowel continence status had deteriorated two levels from continent to occasionally incontinent to frequently incontinent.

Interview with RPN #163 indicated the resident had deteriorated gradually since admission. The resident was presently frequently incontinent of bowel. The RPN indicated that staff was expected to conduct a continence assessment on residents with continence level changes using the tool in the home's electronic health record system. The RPN stated that a continence assessment was not conducted on the resident when the resident's bowel continence level changed during the above mentioned periods from continent to incontinent.

Interview with the administrator confirmed that the resident who was incontinent of bowel did not receive a continence assessment using a clinically appropriate tool when the resident's continence status deteriorated. [s. 51. (2) (a)]

WN #10: 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 SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Review of an identified CI report revealed on an identified date, PSW #125 had been verbally abusive towards resident #031 while providing morning care. The home had failed to notify the family member of resident #031 immediately upon becoming aware of the witnessed incident of abuse that caused distress to the resident that could potentially be detrimental to the resident's well-being. Further the CI indicated the resident's family member had not been notified due to pending investigation.

Review of the resident progress notes from the period when the incident happened failed to reveal any communication to the resident's family member regarding the incident.

Interview with RPN #126 confirmed the resident's family member had not been notified of the incident as he/she had been under the impression that once he/she addressed the issue, it should not be communicated to others.

Interview with the NM #124 confirmed the practice in the home was to notify the resident's family member immediately upon identified or suspected incident of abuse with reasonable information available about what is going on, however he/she was not aware

why this resident's family member had not been notified immediately upon acknowledgment of the incident. [s. 97. (1) (a)]

2. The licensee has failed to ensure in making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to a witnessed incident of inappropriate behavior between resident #026 towards co-resident #028 included the notification of resident #028's family member, person of importance or a substitute decision maker of any resident involved in the incident was contacted and the name of such person(s).

An identified CI report submitted to the MOHLTC revealed that resident #026 had been observed touching resident #028 inappropriately.

Record review of the progress notes for resident #028 revealed resident #028's family member had been contacted the next day, more than 12 hours after the above mentioned incident had occurred.

Interview with RPN #121 revealed he/she had called resident #028's family member the next day more than 12 hours after the incident. RPN #121 further revealed that he/she had not been aware of the reporting requirements and thought that only notifying the RN in-charge had been required. RPN #121 also revealed that he/she was now aware of the reporting requirements to the Director related to abuse.

Interview with NM #124 confirmed that the family member for resident #028 had not been contacted within 12 hours. [s. 97. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

Review of three identified critical incident reports, involving resident #022, #010, and #031, failed to include information indicating the licensee conducted analysis after becoming aware of the incidents.

Interview with the Administrator revealed a Nursing Steering Committee meets monthly and the members, directors of care from the respective homes, discuss all high risk areas.

Review of the most recent Nursing Steering Committee notes revealed the incidents of abuse and neglect had been discussed at the meeting in general but with no analysis of every incident.

Interview with the Nurse Manager confirmed the home had not undertaken analysis of every incident after they became aware of the above mentioned three incidents. [s. 99. (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure when making a report to the Director under subsection 23(2), that a description of the incident, including the area or location of the incident and the events leading up to the incident and, names of staff members or other persons who were present at or discovered the incident were included in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone.

On an identified date, the licensee submitted an identified CI report which revealed resident #026 had been observed touching resident #027 inappropriately.

Further review of the CI report under the description of the unusual occurrence, including events leading up to the occurrence had not included what either resident was doing nor where either resident were situated prior to the incident. The CI report revealed a PSW had witnessed the incident however had not identified the PSW by name.

Interview with RPN #108 revealed that the CI report had required more information leading up to and including the actual incident and that the name of the PSW had not been identified.

Interview with NM #124 confirmed that a description of the incident, including the area or location of the incident and the events leading up the incident including the name of the PSW who had witnessed the incident had not been included in the CI report. [s. 104. (1) 1.]

2. The licensee failed to ensure when making a report to the Director under subsection 23(2), that the long term actions planned to correct the situation and prevent recurrence were included in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone.

Review of an identified CI report revealed on an identified date, PSW #125 allegedly swore at resident #031 when providing morning care. The incident was reported to the DOC six days after the incident occurred. Further review of the CI report revealed the report did not include following analysis as for the long-term actions to correct the situation and prevent recurrence because it depended upon the outcome of the investigation.

Interview with NM #124 indicated that he/she was not sure why this section was not completed and the outcome of the investigation not entered in the CI because he/she was not the person who initiated the CI. However he/she confirmed the long-term action plan to prevent the recurrence and to correct the situation, including reeducation of the staff, should have been entered. [s. 104. (1) 4.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident admitted to the home must be screened for tuberculosis (TB) within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

This inspection is initiated based on record review of the LTCH Licensee Confirmation Checklist and admission immunization screening of residents newly admitted to the Long Term Care Home which stated that all newly admitted residents were to receive a chest X-Ray to rule out active TB.

Review of the Home's policy titled "Tuberculosis Surveillance for Residents" (Policy Number IFC B-05), effective date December 2015 revealed:

All new permanent residents must undergo a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. It is recommended that this assessment include:

1. A symptom review for active pulmonary TB disease.
2. A chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility or within 14 days after admission.
3. In addition to the above, for residents < 65 years of age, and status is unknown, a documented Two-Step is required. If there is a documented Two-Step Test (TST) on file, only a One-Step is required. If a TST was previously done, record the date and result of the most recent TST.

Record review of Admission and Symptom Relief Orders of resident #045 revealed that a TB test was not ordered for the resident on admission on an identified date. Further review of two Health Assessment forms dated seven months apart following admission also revealed that no TB testing was done for the resident.

Interview with RN#143 stated that the RNs will audit and check that residents have TB testing done on admission, and if not, will send a referral to inform the doctor that one has not been done. For resident #045, the doctor crossed off on the Admission Symptom Relief Orders form that resident #045 did not need TB testing done.

Interviews with RPN #145, RN #139, and RN #143 confirmed that there was no

documentation of resident #045's TB testing records on the computer records or the Admission and Symptom Relief Orders form. NM #124 confirmed that according to the Admission and Symptom Relief Order form, the doctor did not order the test and that TB screening was not done for resident #045 on admission to the Long Term Care Home.

Interview with NM #124 confirmed that the resident was not screened for tuberculosis (TB) within 14 days of admission. [s. 229. (10) 1.]

Issued on this 2nd day of December, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TILDA HUI (512), GORDANA KRSTEVSKA (600), IVY LAM (646), JOANNE ZAHUR (589)
Inspection No. / No de l'inspection :	2016_251512_0011
Log No. / Registre no:	019818-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 21, 2016
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF SIMCOE 1110 Highway 26, Midhurst, ON, L0L-1X0
LTC Home / Foyer de SLD :	SUNSET MANOR HOME FOR SENIOR CITIZENS 49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Kamino

To CORPORATION OF THE COUNTY OF SIMCOE, 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) (b)

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 shall prepare, submit and implement a plan to ensure that residents #010 and #031 are protected from abuse by anyone and to ensure that residents #006, #012 and #013 are not neglected by the licensee or staff.

The plan shall include, but not limited to the following:

1. Resident #010's requests for service in dining room will be responded to free from emotional abuse.

2. Resident #031's provision of personal care including dressing will be delivered free from physical and verbal abuse.

3. Resident #006's calls for assistance with toileting will be responded to in a timely manner.

4. Residents #012 and #013 will be attended to as soon as they finish their meals, having their faces washed, their soiled clothing protectors removed, and taken to their rooms for toileting.

5. Process to evaluate the above mentioned strategies to ensure effectiveness in providing quality and safe care to the residents.

6. Development of a plan which will include a schedule to test and monitor staff's performance in adherence to the home's zero tolerance of abuse and neglect program.

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to tilda.hui@ontario.ca by December 6, 2016.

Grounds / Motifs :

1. For the purposes of the Act and in subsection 5 of the Regulation, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

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

anyone and free from neglect by the licensee or staff in the home.

Review of an identified CI report, revealed a complaint voiced by resident #006 that the resident had an incontinent episode of loose bowel movement and had been waiting for 40 minutes to get cleaned up on an identified date. The home initiated investigation upon receiving the complaint.

Interview with the resident indicated the resident was upset with having to wait long to be cleaned up when he/she rang the call bell on the identified date, just before shift change at 2 p.m. on the unit. PSW #165 responded to the resident's call and told him/her to wait until the shift change report was finished. The resident waited for 40 minutes and rang the call bell again. By that time, the resident was in a mess with loose bowel movement and required a complete bed bath to clean up. The resident indicated that he/she had experienced prior incidents of staff delaying to respond to his/her call for assistance especially during shift change report times. The resident was not able to recall details of prior experiences including time frames.

Interview with PSW #104, who was on evening shift and came on at 2 p.m., indicated the resident did experience large amount of loose bowel movement on the identified incident date. PSW #104 responded to the resident's second call bell and provided care to the resident 40 minutes after the resident had initially rang the call bell for assistance. PSW #165, who responded to the first call, was not able to be reached for interview. PSW #104 stated he/she did not receive a message from PSW #165 that the resident was waiting to be cleaned up after shift report was finished.

Review of the call bell report on the incident date, revealed the resident rang the call bell at 2:00 p.m. and the call was responded after 14 minutes. The resident rang the call bell again at 2:33 p.m. and was responded after eight minutes.

Interview with the administrator indicated the length of time the resident waited to be cleaned up on the identified date, was not acceptable and that resident #006 had been neglected by staff at the home.
(512)

2. Review of an identified critical incident report revealed a suspected neglect incident occurred on an identified date, that resident #012 and resident #013 were allegedly being left at the dining table following their identified meal service

until one and a half hour after the meal service had ended without having their faces washed, their soiled clothing protectors removed, and not taken to their rooms for toileting. The POA for the two residents came to visit on the identified date and time, and found both residents still sitting at the dining table. The POA notified the Administrator the next day regarding his/her concerns. The home initiated an investigation and implemented remedial action including revision of the resident's written care plan, posting a note in the dining room to remind staff to remove the two residents as soon as they finished their meals from the dining table, clean their faces, remove their clothing protectors, and take them to their rooms for toileting. Following the investigation, PSW #140 was disciplined for not providing care as per the care plan and was removed from providing care to the residents.

Phone interview held with the family of the POA who had submitted a complaint letter dated two days before the incident date on behalf of the POA, to the home regarding a similar incident noted a day prior, when the two residents were observed still at the dining table one hour and 50 minutes after the meal service had ended.

Review of the investigation notes indicated the two residents had been experiencing medical conditions and were receiving medication to relieve the symptoms. Staff believed due to the medication causing drowsiness, the residents had been more drowsy and was often seen dozing off at the dining table. Staff did try to keep the resident awake for meals however were not successful at times. The residents would be left to eat by themselves until later than usual.

Interview with PSWs #140, #141, and RPN #136 indicated the two residents often came out to meals late and were left to finish later than the other residents, but not as late as stated by the POA. RPN #136 stated that it was 30 minutes after the identified meal service had ended that the POA came to visit on the incident date. Interview with PSW #146 who was on duty on the incident date indicated he/she was assigned to provide care to the two residents on that day. PSW #146 indicated there were a lot of visitors on the incident date requesting staff's attention for their residents. PSW #146 described the day as "chaotic" and admitted that he/she had forgotten to double check if the two residents had finished their meals, removed from the dining table, was cleaned and brought to their room for toileting. PSW #146 stated he/she always checked the residents on his/her assignment prior to completing his/her shift at an identified time,

however, did not do so on the incident date.

Interview with the administrator confirmed that care was not provided to resident #012 and #013 and that the two residents were neglected by PSW #146 on the incident date.
(512)

3. For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by anyone other than a resident that causes physical injury or pain.

Review of an identified CI report submitted by the home on an identified date, revealed that PSW #125 had been abusive towards resident #031 while providing morning care in the resident's room.

Interview with RPN #126 revealed on an identified date, as the RPN was leaving the medication room with the cart to administer medication, the RPN overheard a loud voice coming out of resident #031's room, using inappropriate language apparently directed at the resident. The RPN recognized the voice as one of the PSWs on duty. RPN #126 stated that he/she walked in the room and told PSW #125 that the language he/she used was not appropriate, and his/her voice was too loud. The RPN continued to administer medication to residents down the hall.

Interview with PSW #127 indicated seven days prior to the identified date of the incident, he/she had been providing care to resident #031's roommate in the room. While in the same room, PSW #127 overheard PSW #125 yelling and screaming at resident #031 using profane words and threats. PSW #125 had not been able to get the shirt off the resident because one sleeve was trapped half way on the resident's arm. PSW #125 had been trying to get the shirt off the resident by pulling the resident's hand. Resident had an identified limitation in range of motion of his/her upper limbs and was not able to relax when PSW pressured him/her to cooperate with care. PSW #127 stated the resident had been looking at PSW #125 straight in the eyes saying nothing, but PSW #125 was heard speaking to the resident using inappropriate, vulgar, and threatening languages. PSW #127 stated he/she could not stand how the resident was treated and asked PSW #125 to leave the resident. PSW #127 completed the rest of the care while trying to calm the resident as the resident was visibly upset.

A second interview with PSW #127 further indicated that on the identified incident date, he/she was providing care to resident #031's roommate. At the same time, PSW #125 was providing care to resident #031 and was heard yelling at the resident and was noted to be rough while providing care. At some point RPN #126 entered the room and told PSW #125 that he/she was too loud and was using inappropriate language, and that was not appropriate. PSW #127 reported both incidents to the DOC six days after the identified date of the incident.

Interview with NM #124 confirmed the staff is expected to provide safe care to the resident and to protect residents from abuse and neglect. PSW #125 failed to comply with the home's expectation as well as with the MOH regulation. The home had suspended PSW #125 and offered him/her additional education prior to returning to work. However PSW #125 was no longer an employee of the home.
(600)

4. In accordance with the definition identified in section 2(1) of the Regulation 79/10, "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of wellbeing, dignity or self-worth, that is made by anyone other than a resident.

An identified CI report was submitted to the MOHLTC related to an alleged incident of staff to resident verbal abuse that had occurred on an identified date.

Record review of the most recent written plan of care revealed that resident #024 required two staff assistance with transfers and toileting care needs.

Review of the CI report revealed PSWs #127 and #133 were applying a transfer sling under resident #024 while he/she was seated in a wheelchair. PSW #133 indicated the resident was giving PSW #127 dirty looks and PSW #127 responded by verbalizing an inappropriate comment with profanity.

Interview with PSW #133 indicated he/she reported the incident to the RPN on duty who reported the incident to the RN in-charge. PSW #133 further revealed that he/she had been asked to provide a written statement of what he/she had observed and overheard.

Record review of the home's investigation notes revealed resident #024 had acknowledged that PSW #127 had used profanity on that day, but that he/she had already forgotten about it.

Interview with PSW #127 revealed that it had been possible he/she could have used profanity with resident #024 on the identified date that the incident occurred.

The home's internal investigation notes revealed that PSW #127 had been issued a discipline related to inappropriate language and conduct that had occurred on the above mentioned date.

Record review of PSW #127's personnel file revealed a previous discipline had been issued for inappropriate language and conduct that had occurred six months prior to the above mentioned incident.

Interview with NM #124 confirmed that resident #024 had not been protected from verbal abuse.
(589)

5. Section 2 (1) of the Regulation defines the following types of abuse: "Emotional Abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization by anyone other than a resident.

Review of an identified CI report revealed on an identified date during an identified meal service, resident #010 was emotionally abused by Dietary Aide (DA) #153. DA #153 ignored the resident when the resident asked for a bigger spoon. DA #153 was overheard saying inappropriate comments to the resident relating to payment of services in the home. Then the DA turned to RN #149, who was present in the dining room, rolled his/her eyes and said another inappropriate comment about the resident. DA #153 admitted to RN #149 he/she had always ignored this resident.

Interview with RN #149 indicated the DA had been ignorant and had been intimidating resident #010 during the meal service.

Interview with Nurse Manager (NM) #124 confirmed RN #149 had witnessed the interaction between DA #153 and the resident, and that the home had investigated the incident immediately. The dietary staff had been sent on working leave pending investigation and then he/she had been on sick leave. DA #153 had not come back to work in the home. Further the NM confirmed the home expects the residents to be treated with respect and protected from any kind of abuse and resident #010 was not protected from abuse by DA #153.

The severity demonstrated is actual harm/risk which is noncompliance related to abuse and neglect of residents by the licensee and staff in the home that resulted in outcomes that had negatively affected the residents' ability to achieve their highest functional status. The scope is isolated when one or the fewest number of residents are affected, which is five percent (5%) or less of the affected surveyed population. The home's compliance history is with one or more unrelated noncompliance in the last three years (two full years and current year). The judgment matrix resulted in quadrant G and the issuance of a compliance order is warranted.

(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

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

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect 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 has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Review of an identified Critical Incident (CI) report submitted by the home on an identified date described an incident where PSW #125 had been verbally abusive towards resident #031 while providing morning care on the identified date and seven days prior to the identified date.

Interviews with PSW #127 revealed the PSW was the witness to the two above mentioned incidents at which PSW #125 was verbally abusive and rough when providing care to resident #031. PSW #127 indicated he/she did not report the

first incident to anyone after he/she heard PSW #125 yelling at the resident while PSW #127 was providing care to the roommate.

Interview with RPN #126 revealed on the second incident date, as he/she had been leaving the medication room with the cart to administer medication, he/she had overheard a voice coming out of resident #031's room, using inappropriate language directed at the resident. The RPN recognized the voice as one of the PSWs, walked in the room and told PSW #125 that the language he/she used was not appropriate. The RPN then continued to administer medication to residents down the hall. PSW #127 reported both incidents to the NM on the identified date, and a report was made to the MOHLTC.

Interview with RPN #126 confirmed he/she had not reported the second incident to the RN on duty or to anyone else. The RPN confirmed he/she had not identified the incident as verbal abuse to the resident at the time and therefore did not report it.

Interview with NM #124 confirmed the staff was expected to notify the manager on duty or call the action line number immediately after witnessing or suspecting abuse of the resident, however the staff had been also advised to notify the manager on duty immediately so the home will take immediate action to prevent further abuse and keep the residents safe.
(600)

2. Review of an identified CI report submitted to the MOHLTC on an identified date, revealed an incident of alleged staff to resident verbal abuse that had occurred one day before the identified date.

Interview with PSW #133 revealed he/she had witnessed PSW #127 using profanity while providing care to resident #024. PSW #133 further revealed he/she had been asked to provide a written version of the incident to NM #124 which had been completed on the identified date. PSW #133 revealed they have been instructed to follow the chain of command when reporting any alleged or witnessed incidents of abuse and/or neglect. PSW #133 revealed that the chain of command was as follows: report to RPN who reports to the RN who reports to the DOC or NM who reports to the Director.

Interview with NM #124 revealed that he/she had received an email on the identified date, one day after the incident of verbal abuse and confirmed that the

incident of verbal abuse had not been reported immediately to the Director.
(589)

3. Review of an identified CI report revealed an alleged staff to resident abuse/neglect which occurred on an identified date and time. Resident #015 was found with no pants on and dry feces on his/her legs and was not cleaned up and dressed until two and a half hours later. The incident was reported to the Nurse Manager on the same day however the critical incident report was not submitted to the Director until 25 days later. There was no indication that the home had notified the Director by using the after hours reporting phone line.

Interview with the NM #124 stated that the NM was unsure if this was a case of resident abuse and was planning to investigate to obtain more information before reporting to the Director. Interview with the Administrator confirmed that the suspected abuse/neglect incident should have been reported to the Director immediately as required by legislation.
(512)

4. Review of an identified CI report submitted by the home on an identified date, described an incident of staff being verbally abusive towards resident #022 six days prior to the report date, which was witnessed by laundry staff #132. The CI report revealed the laundry staff overheard a staff member yelling at the resident using inappropriate language while providing morning care. Interview with laundry staff #132 confirmed he/she witnessed the incident on the incident date, but had not reported immediately because he/she was not sure who to report the incident to. After six days and discussion with other staff members, the laundry staff notified NM #124 describing the incident. The laundry staff acknowledged he/she had not followed the guidelines for mandatory reporting and stated he/she should have reported the incident immediately.

Interview with the NM confirmed the home's staff had been encouraged and trained that any witnessed or suspected abuse or neglect is to be reported immediately to the Director and also to the RN on duty so the home will take action to provide safety to the resident.

The severity demonstrated is actual harm/risk which is noncompliance related to the reporting of abuse and neglect of residents by the licensee and staff in the home that resulted in outcomes that had negatively affected the residents' ability to achieve their highest functional status. The scope is isolated when one or the

fewest number of residents are affected, which is five percent (5%) or less of the affected surveyed population. The home's compliance history is with one or more noncompliance in similar areas in the last three years (two full years and current year). The judgment matrix resulted in quadrant G and the issuance of a compliance order is warranted.

(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tilda Hui

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