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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 22, 2017	2017_544527_0007	009294-17	Resident Quality Inspection

Licensee/Titulaire de permis

TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

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

TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

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

KATHLEEN MILLAR (527), BERNADETTE SUSNIK (120), DARIA TRZOS (561), HEATHER PRESTON (640), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 15, 16, 17, 18, 19, 23, 24, 25, 26, 29, 30, 31, June 1, 2, 6, 7, 8, 9, 12, 13, 14 and 15, 2017

During the course of the Resident Quality Inspection (RQI) the following Critical Incidents (13), Complaints (2), Follow-ups (7) and Inquiries (4) were conducted concurrently with the RQI:

Critical Incidents (CIS):

Log #027408-16, CIS #000055-16 - alleged staff to resident abuse;
Log #027879-16, CIS #000056-16 – alleged resident to resident sexual abuse;
Log #028190-16, CIS #000059-16 – alleged resident to resident abuse;
Log #028828-16, CIS #000062-16 – alleged staff to resident abuse;
Log #029807-16, CIS #000068-16 – alleged resident to resident abuse;
Log #030893-16, CIS #000071-16 – alleged resident to resident abuse;
Log #033414-16, CIS #000076-16 – alleged resident to resident sexual abuse;
Log #004257-17, CIS #000008-17 – alleged staff to resident abuse;
Log #005158-17, CIS #000016-17 – alleged staff to Resident abuse;
Log #007598-17, CIS #000023-17 – resident fall;
Log #009166-17, CIS #000027-17 – resident fall;
Log #009976-17, CIS #000029-17 – hot water/boiler issues; and
Log #010729-17, CIS #000032-17 – alleged resident to resident abuse.

Complaints included:

Log #000363-17 related to multiple falls; and
Log #004187-17 related to alleged staff to resident abuse.

Compliance Order Follow-up:

Log #005886-17 – Order re: s. 20. (1) due September 30, 2016 – compliance with the home's Zero Tolerance policy and procedures. This compliance Order was complied by LTCH Inspector #527.

Other Compliance Orders for Follow-up Inspection included:

Log #007000-17 - Order re: s. 43. due March 31, 2017- communication;
Log #007001-17 - Order re: s. 6. (7) due March 31, 2017 – plan of care;
Log #007004-17 - Order re: s.90. (1) due March 31, 2017 – maintenance;
Log #007006-17 - Order re: s. 110. (1) due March 31, 2017 – restraints;
Log #007007-17 - Order re: s. 221. (1) due March 31, 2017 – training; and
Log #007009-17 - Order re: s. 110. (2) due March 31, 2017 – restraints.

The Inquiries included:

Log #029797-16, CIS #000069-16 – bruising of unknown origin;

Log #010180-17, CIS #000028-17 – resident fall;
Log #011023-17, CIS #000034-17 – alleged staff to resident abuse; and
Log #007015-17, CIS #000022-17 – alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the owner of the home, the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Services Coordinator (RSC), the Continuous Quality Improvement (CQI) Risk Coordinator, the Resident Assessment Instrument (RAI) Coordinator, the Food Services Manager (FSM), the Activities Coordinator, the Registered Dietitian (RD), the Behavioural Support Ontario (BSO) staff, the Continence Care, Falls and Skin and Wound Leads, Nurse Managers (NMs), registered nurses (RNs), registered practical nurses (RPNs), physiotherapist, physiotherapy assistant (PTA), recreation aides, dietary aides, maintenance workers, housekeeping staff, personal support workers (PSWs), residents and family members.

The Inspectors also toured the home, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (2)	CO #006	2016_467591_0010	561
O.Reg 79/10 s. 221. (1)	CO #005	2016_467591_0010	527
O.Reg 79/10 s. 43.	CO #002	2016_467591_0010	561
O.Reg 79/10 s. 90. (1)	CO #003	2016_467591_0010	120

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 O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

During interview of resident #047, the Long Term Care Home (LTCH) Inspector#640 noted the resident's toe nails to be long with debris on them.
The clinical record revealed the resident had signed a consent for podiatry services to be provided every four to six weeks but the resident was not included on the podiatry services list.
The written plan of care directed staff to trim finger and toe nails on bath days as needed.

Review of the home's policy called "Personal Hygiene & Grooming", Index: NAM-K-01 and revised May 2016, directed staff that nail care was to be completed during the bathing routine and at other times as needed. "This may include but not limited to: trimming and cleaning".
Resident #047 was observed in bed in June 2017 with their toenail impaired.
Registered nurse (RN) #105 was interviewed and confirmed the resident's toenails were not trimmed and should have been. The RN told the LTCH Inspector the home does not provide any toenail care or trimming and that only the podiatrist does the toenails.
Review of the PSW documentation with the RN demonstrated the resident's toenails had been trimmed on three occasions; the RN informed the LTCH Inspector that they could not have been trimmed as the home staff does not provide toenail care to the residents.
The Resident Services Coordinator (RSC) was interviewed and they indicated that the home does not provide any form of toenail care to the residents.
Interview of resident #047 and family revealed that they were not aware that the home could provide basic toenail care at no charge.
Interview of resident #016 revealed that they were not aware that basic toenail care could be provided by the home at no charge. The only offer for toenail care was the podiatrist at an extra cost to the resident. The resident stated they would prefer that, as would their power of attorney for finances as they found the fees an added burden of expense.
Interview with resident #036 also revealed that they were not aware the home could provide basic toenail care at no extra charge. During the admission process, the resident was not offered the option. They had been told about the podiatry service only and had to sign the contract for the service and pay the fees. The resident went on to say they believed other residents' were also not aware.
The Administrator told the LTCH Inspector they were not aware the home did not provide

basic toenail care to residents and the home was required to provide and offer basic toenail care at no cost to the resident.

The home failed to ensure that resident #016, #036 and #047 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. [s. 35. (1)]

2. The licensee failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

A) The home's policy called "Personal Hygiene & Grooming", Index: NAM-K-01, and last revised April 2017, directed staff to complete nail care during the bathing routine of the resident and at other times as needed.
The clinical record for resident #013 was reviewed and identified that based on the Resident Assessment Instrument - Minimum Data Set Assessment (RAI-MDS) dated April 23, 2017, the resident was moderately impaired cognitively. The resident's written plan of care indicated that fingernail care was to be provided on bath days as needed.
The resident's bath schedule was reviewed and the resident had a bath two times during a specific week in May 2017.
Resident #013 was observed in May 2017. The resident's fingernails were trimmed; however there was debris under their nails.
PSW #113 was interviewed and confirmed that resident #013's finger nails would be trimmed and cleaned on bath days, when personal hygiene was provided each day and when needed. The PSW confirmed resident #013's fingernails were not cleaned as per their policy.
RN #106 confirmed that PSWs were expected to provide fingernail care during bath days, during personal hygiene and as needed. (527)

B) Resident #020 was observed on three occasions in May 2017, with long, uneven fingernails with debris.
The home's policy called “Personal Hygiene and Grooming”, Index: NAM-K-01, and revised April 2017, directed staff to provide fingernail care during the bathing routine and at other times as needed. This may include, but not limited to, trimming and cleaning.
The written plan of care directed staff to re-approach using Gentle Persuasive Approach (GPA) when care was refused and to offer manicure on a monthly basis. Review of the documentation in Point of Care (POC), revealed the resident had fingernail care completed on six occasions in May 2017. There was no task set up for monthly manicure and no documentation that this occurred.

Interview of PSWs #101 and #113, indicated what the interventions were in place and to call the family.
Interview of RPN #131 confirmed the resident's behaviours. Interventions were not in place to address the resident's actions or address the need for additional cleaning of the resident's fingernails. RPN #131 also informed the LTCH Inspector that this action was not a responsive behaviour and the resident had not been assessed by supports in place related to responsive behaviours.
The Administrator was interviewed in May 2017, and told the LTCH Inspector that the resident refused to have nail care done by staff. If the resident says no it's no.

The home failed to ensure that fingernail care was provided to resident #013 and #020.

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff.

A) The critical incident report submitted to the Director in March 2017, indicated that there was an incident of alleged physical abuse that occurred in March 2017, by PSW #153 towards resident #052.
The investigation notes indicated that in response to the resident's responsive behaviour, the physical actions taken by PSW #153 to respond to the resident's behaviour.
RN #155 witnessed the incident and told the PSW to stop; however the PSW said that they could not. The RN stepped in between the PSW and the resident to de-escalate the situation.

Resident #052 was interviewed and was able to recall some of the details of the incident. They stated that they remembered the PSW and what they had done. The resident stated that the PSW caused pain and this was not the only thing the PSW had done; resident stated that they hit them and twisted their finger. The resident became teary and stated that they were afraid of PSW #153.
During an Interview, RN #155 indicated that in March 2017, they came off the elevator on the third floor and observed registered staff and PSWs standing at the nursing station and heard someone yell. Another registered staff indicated that it was resident #052. RN #155 went to see what was happening and when they entered the room they saw how PSW #153 was treating the resident. The resident sustained an injury and indicated that they were in pain. The RN stepped in and told the PSWs to leave.
RN #155 further indicated that the way the PSW was treating the resident during the incident was unacceptable, instead of calling for help when the situation escalated and leaving the resident alone, PSW #153 was provoking them and was yelling back at the resident.
During an interview, PSW #153 stated that the resident was agitated and they had to prevent the resident from hitting them. PSW #153 indicated that during the incident they did not believe there was any harm done to the resident. The PSW stated that the resident was used to situations like this as this was not the first time they had such behaviours.
During an interview, PSW #154 stated that the resident was having behaviours and they acted in a way, which caused no harm to the resident. PSW #154 denied that PSW #153 was rough with resident #052 or yelling at the resident. PSW #154 indicated that they should have gone to get help to de-escalate the situation.
The investigation notes indicated that PSW #153 received disciplinary action for the way they handled the situation.
The ADOC and DOC confirmed that the actions of PSW #153 were abusive towards the resident. (561)

B) During stage 1 of the Resident Quality Inspection (RQI), resident #020 told the Long Term Care Home (LTCH) Inspector#640 that PSW #117 provided care forcefully despite the resident telling the PSW not to do so. The resident stated that they yelled at the PSW to stop but the PSW continued. The resident shared with the LTCH Inspector the staff member had been moved to another area in the home. If the person were to work with them again or be seen by them, they would be very frightened. Resident #020 documented the incident in their own hand writing, that included the date of the occurrence in February 2017.
Review of the clinical record identified the resident's family member called the home in

February 2017, after the incident, to inform the home of the note they had received from the resident, regarding the incident. The family member lodged a complaint with the Ministry of Health and Long Term Care (MOHLTC) in February 2017. The home submitted a critical incident report to the Director the following day.
Interview with PSW #117, revealed the resident required specific care and they told the LTCH Inspector the resident did not scream or yell.
Interview with RN #149, the nurse in charge during the shift, who told the LTCH Inspector the resident did not want to have care but the RN had talked them into it. The RN stated they did not hear anything during the resident's care as they were not on the unit.
The DOC confirmed that the care provided to resident #20 by PSW #117, was a form of abuse of the resident. The PSW was disciplined, was required to complete re-education about abuse and neglect, and was permanently transferred to another home area to work as a result of the incident. (640)

C) Resident #046 was known to staff to exhibit sexual responsive behaviours. These behaviours were primarily targeted at resident #045. Strategies were developed and implemented; however the resident was known to remove any door barrier and subsequently this intervention was assessed as being ineffective and discontinued. A number of other strategies were developed and implemented to manage the resident's behaviour. The home transferred resident #046 from one floor to another in December 2016. Although resident #046 was transferred to another resident care unit, resident #046 continued to exhibit sexual responsive behaviours to other residents.

(i) In May 2016, staff observed resident #046's exhibiting sexual responsive behaviours to resident #045.

(ii) In November 2016, resident #046 was observed by staff exhibiting sexual responsive behaivours to resident #045.

(iii) In December 2016, resident #046 was trying to call resident #045 to their room and exhibiting sexual responsive behaviours to resident #045's. Staff reminded resident #046 not to touch another resident in a sexual manner. In addition, resident #046 was observed by staff when they removed the barrier from their room, stayed by the doorway and trying to call resident #045 to their room.

(iv) In December 2016, resident #046 was observed by staff when they tried to remove the door barrier again from their room, and later on the same day they were observed by staff trying to call resident #045 to their room.

(v) Again, in December 2016, resident #046 was observed signalling to a co-resident to go towards another area of the unit. The staff subsequently heard the two residents talking. Resident #046 was told by staff to leave the other resident alone.

(vi) In January 2017, resident #046 was seen by staff exhibiting sexual responsive behaviours towards resident #052 and the residents had to be separated.

Resident #046's clinical record was reviewed, staff to resident and resident to resident interactions were observed throughout the RQI, and staff were interviewed. The clinical record revealed that there were no referrals to the Psychogeriatric Resource Consultant (PRC), which the home would do if the responsive behaviour strategies were ineffective, and as an additional resource to assist in managing the resident's responsive behaviours. There was no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessments conducted since May 2016. The Behavioural Support of Ontario (BSO) RPN #157 had indicated in their documentation that they would conduct a PIECES assessment; however this was also not completed for resident #046. The BSO RPN #139 and PSW #127 were interviewed and confirmed that the DOS charting of the resident's behaviour for seven days was expected to be completed by the staff after the November 2016, incident in order to determine if there was a pattern and a frequency to the resident's behaviour, and they were unable to locate the documentation. The BSO staff confirmed that based on their clinical pathway for responsive behaviours, the BSO should have conducted a P.I.E.C.E.S. assessment and refer to the PRC for assessment, but neither were done.
The DOC and ADOC were interviewed and confirmed that there were no referrals to PRC, when there should have been and the P.I.E.C.E.S. assessment by their previous BSO was not completed to assist in managing the resident's responsive behaviours. The DOC and ADOC confirmed that resident #046 had sexual responsive behaviours prior to and after the critical incident in November 2016, with the same resident #045, and subsequently with other residents on another floor. The DOC and ADOC confirmed that resident #046 was moved to another unit as one intervention to manage their sexual responsive behaviours towards resident #045; however this strategy was not implemented until the first week in December 2016, and subsequently resulted in resident #046 continuing to exhibit sexual behaviours towards other residents on the new unit and was not effective.
The ADOC and the BSO staff confirmed that the strategies implemented for resident #046 were to not only manage this resident's sexual responsive behaviours, but to prevent these behaviours from continuing towards female residents. They confirmed that

the strategies were not effective in protecting other residents.
The home failed to protect residents from resident #046's sexual responsive behaviours.

The home failed to ensure that resident #020, #045 and #052 were protected from abuse by anyone.

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

s. 6. (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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #005 was at high risk for falls and when ambulating in April 2017, they sustained an injury.
The resident was observed on three occasions in March 2017, and was observed to have a falls prevention intervention in place for their wheelchair.
PSW #116 was interviewed and indicated that one of the interventions for falls was that the resident had the had another falls prevention in place when in bed.

Interview with the RN #107 confirmed that the resident had the specific interventions in place as one of the strategies to prevent falls.
The current written plan of care was reviewed and stated that the resident required these falls prevention interventions in place at all times when in bed.
The ADOC was interviewed and confirmed that the resident had the falls prevention interventions in place both in bed and while in wheelchair and confirmed that the written plan of care did not include this intervention.

The home failed to ensure that the written plan of care for resident #005 set out the planned care for the resident in relation to falls interventions.

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A) Resident #005 had a written plan of care indicating that they required several staff to assist with transfers and used a device for locomotion.
Part of the plan of care for each resident was a board above the bed that directed staff on how to transfer residents and directed staff on what type of device residents used for locomotion.
Resident #005's room was observed in May 2017, and the board above the bed had a picture indicating the resident used a specific device for locomotion and required one person for transfer.
The Physiotherapist (PT) was interviewed in May 2017, and confirmed that the resident's device and number of staff for transferring. The PT also confirmed that staff use the picture board by the bedside for direction on how to transfer residents.
PSW #129 who did not provide direct care to the resident was interviewed in May 2017, and after looking at the board in the resident's room they confirmed the incorrect device and number of staff for transferring the resident.
During an interview, RN #107 confirmed that the resident's needs for transferring and the specific device for locomotion. The RN confirmed that the picture with instructions above the bed was wrong and was not consistent with the written plan of care.

The home failed to ensure that the staff collaborated with each other in the implementation of the plan of care for resident #005 so that different aspects of care were integrated and consistent with each other related to transfer and mobility status.

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

A) Resident #041 had a plan of care indicating that they were at high risk for falls and required to have a specific falls prevention strategy implemented at all times. The resident was observed in May 2017, sitting in a specific type of chair in the hallway and the falls prevention device was not working correctly. The device was checked and was not properly attached to the device. The device was turned off. PSW #134 checked the device and confirmed that it was not turned on. The PSW confirmed the resident should have had the falls prevention device on and functioning at all times. Interview with the RN #135 confirmed that the device should have been on at all times and functioning. (561)

B) The plan of care for resident #005 was reviewed and indicated that the physician ordered staff to collect a sample for testing at the beginning of February 2017.
The clinical record was reviewed and there was no evidence that the staff collected the sample or tried to collect the sample as ordered by the physician.
The progress note on a specific date in February 2017, stated that on that day the staff were unable to collect the sample from the resident. The communication book for the physician was reviewed and no evidence was found that staff documented whether they tried to collect the sample during the first week of February 2017.
Interview with the RN #107 indicated that when there was a physician's order for the sample, the staff would try to collect in the evening of the day that it was ordered and if resident refused or staff were unable to collect the sample this should have been documented as such in the progress notes.
The RN reviewed the clinical record and confirmed that the sample was not collected and staff did not try until four days after the physician ordered the sample for testing. (561)

C) Resident #037 was interviewed and informed the LTCH Inspector #640, that their mobility device had been broken for approximately one month and they were having to eat all their meals in bed.
When the resident's clinical record was reviewed, the LTCH Inspector noted that on a specific date in April 2017, part of resident #037's mobility device fell off. The progress notes identified on four dates in April 2017, the resident had been kept in bed due to the broken mobility device. The resident's written plan of care directed staff that the resident was to eat all meals in the dining room.
Interview with PSW #101 and #102, who both told the LTCH Inspector #640, that resident #037 had remained in bed for several days. Interview with RN #105 and RPN #115, who both confirmed the resident had been bedridden. They also confirmed that

resident #037 normally would be up in their mobility device for the day. The resident ate meals in bed and was left socially isolated in their room as a result of being bedridden. RN #105 and the DOC were interviewed and confirmed that it was the expectation of the home that all residents were to be assisted out of bed at their preferred wake time and taken for all meals unless contraindicated due to illness. (640)

D) LTCH Inspector #640 interviewed resident #047 in the presence of their family regarding a concern about care provided to the resident. During the discussion, the resident and their family told the LTCH Inspector the resident preferred that both bed rails be in a certain position when the resident was in bed to assist resident when staff provided repositioning every two hours.
The resident was observed multiple occasions with the bed rails down. Further observation in May and June 2017, saw the bed rails to be down while the resident was in bed.
Review of the written plan of care dated March 2017, directed staff that both the bed rails were to be in the up position for bed mobility.
Interview with PSW #125 revealed that staff did not put the bed rails up when the resident was in bed. Interview with RPN #114 confirmed that resident #047 was not to have the bed rails up. Interview with RN #105 revealed the resident was not on the list of residents using bed rails, had a "no side/bed rail" logo above the bed yet when the RN reviewed the written plan of care, they identified that both rails were to be in the up position when resident in bed. They confirmed the bed rails had not been used and they should have been in the up position to assist with bed mobility. RN #105 confirmed the plan of care was confusing and not consistent, integrated or complemented each other. (640)

The home failed to ensure that the care set out in the plan of care was provided to resident #005, #037, #040 and #041, as specified in the plan.

4. The licensee 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, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #050 had a history of responsive behaviours as indicated in the plan of care. The current written plan of care was reviewed and indicated that one of the interventions when the resident demonstrated behaviour was to remind the resident that the staff will call the resident's family and let them know about the resident's behaviour.
The interview with the BSO PSW #127, BSO RPN #139 and the ADOC in May 2017,

confirmed that this was an intervention that was recommended by the resident's family and seemed to work in the past; however, it had not been used in a while and had not been effective.
The resident's clinical record was reviewed and there was no evidence found to determine when the intervention was discontinued.
The ADOC confirmed that this intervention should have been discontinued some time ago when it was no longer necessary. (561)

B) During observation of resident #058, as a result of a critical incident report inspection, the resident was found to be in bed with the wheelchair at the bedside on two occasions in June 2017. During an afternoon in June 2017, the resident was observed to be in a mobility device.
Review of the clinical record noted the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) dated March 2017, as a "Significant correction to prior quarterly assessment", assessed the resident as to how they were to ambulate. The RAI-MDS assessment dated May 2017, as an "Annual assessment", assessed the resident as no longer able to ambulate and required the use of a mobility device as a result of deterioration in activity of daily living.
Review of the written plan of care dated May 2017, directed staff to provide specific assistance for short distances.
Interview with RN #105 and RN #106, who told the LTCH Inspector, the resident was no longer able to ambulate but required a specific mobility device.
During review of the clinical record, the LTCH Inspector noted the written plan of care, dated May 2017, included a specific mobility intervention.
Review of the Exercise Program Attendance forms and the Follow Up Question Report, as provided to the LTCH Inspector by the Manager of the Activity Program, identified the resident attended this club twice during the month of March 2017, and no attendance for the months of April and May 2017.
Interview with the Manager of the Activity Program identified that the resident had physical decline and was no longer able to attend their program since April 2017, and the reassessment and revision to the plan of care was not completed until June 2017.

The home failed to ensure that the plan of care was reviewed and revised when the care set out in the plan was no longer necessary for resident #050 and #058.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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 failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours.

A) Resident #043 had a history of responsive behaviours, as well as sexual behaviours which were exhibited in January and September, 2016. The sexual behaviours exhibited by resident #043 occurred in September 2016.
The clinical record was reviewed and based on the RAI-MDS in November 2016, the resident's behavioural symptoms had deteriorated since the previous assessment in September 2016, related to the resident being resistant to care. The written plan of care dated November 2016, identified that the resident had a history of an identified behaviour towards a co-resident. There was no date or identification of which co-resident the written plan of care was referring to, and there was no behavioural triggers identified. The "Behavioural SBAR (Situation, Background, Assessment and Recommendations) - Huddle Communication" Tool was reviewed and it did not include any triggers.

RPN #126 was interviewed in June 2017, and they were not aware of the triggers that caused the resident's sexual behaviours in September 2016. The RPN shared that they felt that it was the other resident #044 who initiated the sexual activity.
BSO RPN #139 and BSO PSW #144 were interviewed and they were not aware of what the triggers were for resident #043's sexual behaviours and indicated that this would be identified when the interdisciplinary team conducted the Behavioural SBAR Huddle. The Behaviour SBAR Tool was reviewed by the BSO staff and they indicated that it was incomplete. The BSO staff indicated that when the triggers were identified for residents with responsive behaviours, then the team was able to individualize the strategies to manage the behaviours.
The DOC and ADOC were interviewed and they were not aware of the triggers for resident #043's sexual behaviours and were unable to find the triggers on the resident's clinical record. (527)

B) Resident #046 was exhibiting sexual responsive behaviours and on a specific date in November 2016, the resident was observed by staff exhibiting sexual behaviours towards resident #045.
The resident's clinical record was reviewed and based on the "Behavioural SBAR (Situation, Background, Assessment and Recommendations) - Huddle Communication" Tool there were no behavioural triggers identified; however it did indicate that the resident had a history of inappropriate sexual behaviours related to touching and kissing another resident. There was also no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessment completed on the clinical record, which would have assisted in identifying behavioural triggers.
The BSO RPN #139 and PSW #127 were interviewed and confirmed that based on their clinical pathway for responsive behaviours, the team conducts the SBAR Huddles and that helps to identify triggers for behaviour and that the BSO would usually conduct a P.I.E.C.E.S. assessment to assist the team identifying behavioural triggers.
The DOC and ADOC were interviewed and they confirmed that they did not know what the behavioural triggers were for the resident's responsive behaviours and were unable to locate any information related to triggers on the resident's clinical record and in discussion with their staff. The DOC and ADOC confirmed that the SBAR Huddle tool was incomplete and did not assist in identifying behavioural triggers, and there was no P.I.E.C.E.S. assessment, which would have also assisted in identifying the behavioural triggers for resident #046.

C) The RAI-MDS quarterly assessment dated May 2017, for resident #061 indicated that the resident had physically abusive behavioural symptoms and this behaviour occurred

one to three days in the last seven days. This was a change in behavioural symptoms and the resident deteriorated. The previous RAI-MDS assessment dated March 2017, resident had no behavioural symptoms identified.
The Resident Assessment Protocol (RAP) dated May 2017, indicated that behavioural symptoms had triggered as the resident was noted to have exhibited physically abusive behaviour.
The clinical record review revealed that behavioural triggers were not identified for the resident #061 when they exhibited responsive behaviours.
Interview with the BSO RPN #139 confirmed that the behavioural triggers once identified were to be documented in the care plan.
The home's policy called "Responsive Behaviours Program Overview", Index: SP-B-10, and effective January 2014, directed staff to identify the causes and triggers to prevent responsive behaviours.
The ADOC confirmed that the behavioural triggers were not identified for resident #061.

The home failed to ensure that behavioural triggers for resident #043, #046 and #061were identified to assist in managing the residents' responsive behaviours.

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (b) strategies were developed and implemented to respond to these behaviours, where possible.

A) A critical incident report was submitted to the Director on a specific date in May 2017, in relation to resident to resident alleged physical abuse. The critical incident report indicated that resident #061 allegedly pushed resident #060 on a specific date in May 2017, causing them to fall; however this incident was not witnessed by staff or any other residents. Resident #060 sustained an injury and was sent to hospital for further assessment. Both residents were deemed to be cognitively impaired.
The clinical record review indicated that resident #061 was on Dementia Observational System (DOS) monitoring while this incident occurred as a result of the previous responsive behaviour on a specific date in May 2017. The RAI-MDS quarterly assessment dated May 2017, indicated that the resident had physically abusive behavioural symptoms and this behaviour occurred one to three days in the last seven days and this change in behavioural symptoms had deteriorated. The previous RAI-MDS assessment dated March 2017, indicated that the resident had none of these behaviours.
The RAP dated May 2017, indicated that behavioural symptoms had triggered as the resident was noted to have exhibited physically abusive behaviour. The RAP also indicated that the resident was at risk for harming others as well as themselves, and care

plan goals and interventions were reviewed by the care team to ensure effective interventions were implemented to improve their overall behaviour.
On a specific date in May 2017, the staff initiated an SBAR huddle as a result of the responsive behaviour.
The interviews with PSW #102 and RPN #114 confirmed that the resident had behaviours. RN #135 was also interviewed and confirmed the resident had been placed on DOS monitoring on a specific date in May 2017, as per the SBAR Huddle recommendation and continued to be on DOS monitoring while this incident occurred.
The written plan of care was reviewed and did not address the responsive behaviours and no strategies were documented in the written plan of care to address these behaviours.
Resident #061 was observed in June 2017 sitting with other residents in the room calling out, no staff attended to the resident. RN #135 stated that this was the resident's usual behaviour.
The ADOC was interviewed and confirmed that the plan of care and strategies were not developed and implemented to respond to resident #061's responsive behaviours. (561)

B) Resident #043 had a history of responsive behaviours related to resisting and refusing care, as well as sexual behaviours, which were exhibited in January and September, 2016. The sexual behaviours exhibited occurred on a specific date in September 2016, whereby resident #043 was observed by the staff exhibiting sexual responsive behaviours towards resident #043.
The clinical record was reviewed and based on the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) in November 2016, the resident's behavioural symptoms had deteriorated since the previous assessment in September 2016.
The written plan of care dated November 2016, identified that the resident had a history of exhibiting behaviours towards a co-resident. There was no date or identification of which co-resident the written plan of care was referring to, and there was no strategies developed or implemented to respond to the resident's sexual behaviours. The LTCH Inspector #527, identified that in May 2014, the home "RESOLVED" the strategies and interventions to reduce the incidents of inappropriate sexual behaviours the resident was exhibiting. The Behavioural SBAR - Huddle Communication Tool was reviewed and it did not include any recommendations or interventions and did not indicate that the resident's plan of care was reviewed and revised.
RPN #126 was interviewed and they were aware of the incident and that the resident that caused the resident's sexual behaviours on a specific date in September 2016, was resident #044. The RPN, who did not witness the incident, indicated that it was resident #044 who initiated the sexual activity with resident #043.

BSO RPN #139 was interviewed along with BSO PSW #144, they were not aware of what the strategies were developed and implemented to manage the resident's sexual behaviour in September 2016. They indicated that when the interdisciplinary team conducted the Behavioural SBAR Huddle after the incident then they should have updated the written plan of care with new strategies or reviewed the current strategies to address the resident's sexual behaviours.
The DOC and ADOC were interviewed and they were unable to identify what strategies were developed and implemented to respond to resident #043's sexual behaviours.

The home failed to ensure that strategies were developed and implemented to respond to these responsive behaviours for resident #043 and #061.

3. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) Resident #020 triggered for inspection for having unclean fingernails. During the inspection process, the resident was observed on five occasions in May and June 2017, with debris under their fingernails. On a specific date in May 2017, the resident was observed at lunch with two other residents. On a specific date in June 2017, the resident was observed with debris under their fingernails. The resident's hands had an odour.
Interview of PSWs #101, #113 and #148, RPN #131, RN #106 and the Administrator who told the LTCH Inspector #640, that resident #020 frequently refused care.
Interview of the family member who told the LTCH Inspector the resident only preferred a particular PSW to provide care and does not like care by people they were not familiar with.
The plan of care directed staff to provide nail care on bath days and as needed. If the resident refused care, staff were directed to re-approach after five to ten minutes. If the resident still refused care, staff were directed to call the Power of Attorney (POA) and inform them about the situation.
The clinical record revealed there were no assessments and reassessments completed by the home, related to responsive behaviours and no documentation of responses to interventions.
Interview with RN #106, RPN #139 and the Administrator who confirmed the resident had not had any assessments or reassessments completed for the responsive behaviour of refusal of care and there was no documentation regarding the resident's responses to the interventions. (640)

B) Resident #045 had responsive behaviours, which were manifested in their wandering of the hallways and in and out of other resident rooms. On a specific date in November 2016, resident #045 wandered into resident #046's room. Resident #046 was observed by staff exhibiting sexual responsive behaviours towards resident #045.
The clinical record was reviewed and the written plan of care, dated September 2016, directed the staff to monitor resident #045's location every 30 minutes and document on the wanderer's checklist.
The home's policy called "Wandering Resident Protocol", index NAM-J-10 and effective date January 2014, directed staff that if a resident was at risk for wandering they were to document on the monitoring record and this would be kept on the resident's file once completed.
The resident was observed on four occasions in June 2017, wandering the unit. On two specific dates in June 2017, resident #045 was observed wandering into another resident's room and just as they were entering the room, PSW #134 re-directed the resident.
PSW #146, #147 and RPN #115 were interviewed and indicated that one of the interventions to manage the resident's responsive behaviour of wandering was to allow the resident to wander on the unit, check on the resident every 30 minutes and document on the wanderer's checklist.
The BSO RPN #139 and PSW BSO #127 were interviewed and confirmed that the monitoring every 30 minutes for the resident was in response to their wandering behaviours and the intervention ensured the resident's safety and they were protected.
The DOC and ADOC were also interviewed and confirmed the intervention for monitoring the resident every 30 minutes was to ensure the resident was safe and that they were protected. The DOC and ADOC indicated that the monitoring of resident #045 was expected to be documented on the wanderer's checklist by the staff.
The home failed to ensure that the staff documented resident #045's behaviours on the DOS monitoring sheet. (527)

C) The clinical record was reviewed for resident #061, which indicated that the resident demonstrated behaviours on a specific date in May 2017. The clinical record identified that this was a new change in behaviour. The Behavioural SBAR - Huddle Communication Tool that assessed a new incident of responsive behaviour indicated that the resident was being placed on DOS monitoring.
The interview with RPN #152, who initiated the SBAR huddle stated that they remember initiating DOS monitoring. The resident's hard copy chart was reviewed and the DOS monitoring could not be found. RPN #135 reviewed the progress notes and the resident's

chart and could not find the DOS monitoring checklist and staff did not document in the progress notes whether one was started on a specific date in May 2017.
The ADOC was interviewed and confirmed that the home could not find the DOS charting that was initiated on a specific date in May 2017; however they found one that started on eight days later.
The home failed to ensure that the staff documented resident #061's responsive behaviours on the DOS monitoring sheet. (561)

D) Resident #005's plan of care was reviewed and indicated that they had a history of a specific infection, was at high risk for falls, and had a cognitive impairment.
Review of the clinical record revealed that the resident had responsive behaviours; however these behaviours had increased in the month of March and April 2017. The behaviours. The progress notes for a specific date in February 2017, indicated the resident was exhibiting responsive behaviours. On a specific date in March 2017, the resident continued to have increasing responsive behaviours.
The Electronic Medication Administration Record (EMAR) for the month of March 2017, was reviewed and indicated that medication was ordered by the physician as needed (PRN) and was given to the resident on three specific dates and times in March 2017.
The medication was also given a number of times in the month of April 2017.
The progress notes indicated that the resident had responsive behaviours and on two specific dates in April 2017, the resident was discovered by a PSW had fallen.
On a specific date in April 2017, a referral was done to the Behaviour Supports Ontario (BSO).
On another date in April 2017, the resident fell again and injured themselves.
Upon arrival at the hospital the resident was assessed for possible infection and the laboratory results confirmed the infection.
Interview with the registered staff #107 indicated that it was the expectation that a physician was called and an order obtained for samples for testing of residents that displayed increased behaviours and were cognitively impaired. Increased behaviours could be a sign or symptom of an infection. Resident #005 had a history of infection and had exhibited increased responsive behaviours.
Interview with the DOC and ADOC on May 29, 2017, confirmed that resident #005 was unable to express their needs or communicate. They also confirmed that resident #005 had a history of infections and if residents displayed symptoms of restlessness registered staff were expected to get an order for a sample to be tested.
The Administrator was interviewed on a specific date in May 2017, and stated that they would trust that nurses possess nursing judgement and skill to know when to call the physician if residents require to get an order for a sample for testing. Furthermore, if a

resident displayed increased behaviours and this was the only indication of a possible infection for a resident who is cognitively impaired or cannot communicate their needs, it would be an expectation that the physician was called for further direction.
The Responsive Behaviours policy, index SP-B-05, effective January 2014, indicated that "responsive behaviours is a term used to describe a means by which persons with dementia or other conditions may communicate their discomfort with something related to for example, the physical body, e.g. urinary tract or other infection, therefore an interdisciplinary assessments are carried out and problem solve for possible solutions an one of them being possible causes of behaviour to be investigated further".
Resident #005 had a history of infections, was cognitively impaired, had increased behaviours, had three falls within a few days, and the third fall which resulted in an injury. The tests completed upon arrival at the hospital indicated that resident had an infection. The home failed to ensure actions were taken to respond to the needs of resident #005, including assessments and reassessments. (561)

E) A critical incident report was submitted to the Director indicating that resident #007 was physically abusive to resident #051 on a specific date in October 2016.
Resident #007's clinical records were reviewed and indicated that the resident did not have a history of responsive behaviours. The progress notes revealed that on a specific date in October 2016, resident #007 had increased responsive behaviours. Registered staff obtained an order from the physician for as sample for testing in the first week of October 2016.

On a specific date in October 2016, the resident allegedly physically abused resident #051.
On a specific date in October 2016, the progress noted indicated that the staff tried to collect a sample for testing but it was inadequate.
On a specific date in October 2016, it was documented that the staff were unable to collect a sample for testing as resident refused.
On a specific date in October 2016, the resident had behaviours of wandering.
On a specific date in October 2016, the resident was seen by the physician; however no documentation was found indicating that the doctor was aware of the fact that resident had been refusing the sample for testing and no new orders were obtained.

Interview with RPN #130 indicated that they could not recall if the physician was notified about the resident refusing the sample for testing. If they did, it would have been documented in the communication book.
The ADOC reviewed the communication book with LTCH Inspector #561 and there were

no notes provided to the doctor about the resident refusing the sample for testing in the month of October 2016. Furthermore, on a specific date in October 2016, the progress note stated that the staff could not collect the sample again; however later on that day the sample was collected.
On a specific date in October 2016, the laboratory result came back indicating that the sample was contaminated. Two days later in October 2016, the progress note indicated that staff were unable to collect the sample for testing again.
Resident #007 was seen by the physician on a specific date in October 2016; however the physician was not notified of the resident was refusing the test a second time. The following day, the progress notes indicated that the resident was confused and staff were unable to collect the sample. Towards the end of October 2016, staff were able to collect the sample. The results of sample came back positive for infection and a physician's order was obtained for treatment.
Interviewed RN #107, who indicated that if staff were unable to collect the sample several times, the physician should have been called to reassess and possibly an order for procedure should have been obtained for collection of the sample.
The ADOC was interviewed in June 2017, and indicated that the physician should have been called earlier for a treatment order because the resident had symptoms of an infection and the staff were not able to collect the sample.
The home failed to ensure that actions were taken to meet the needs of resident #007, who was demonstrating an increase in responsive behaviours included reassessment of the resident. (561)

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record each resident's weight monthly.

A) Resident #054 was at moderate nutrition risk and had a specific goal weight range. Resident #054's weight declined in May, below the resident's goal weight range. There were no documented weights for March and April 2017.
In an interview with the Registered Dietitian (RD) in May 2017, it was confirmed that resident #054 did not have a recorded weight for March and April 2017.

B) Resident #053 was at high nutrition risk and had a Body Mass Index (BMI), which was defined as "very severely underweight". Resident #053's weight had decreased.
A review of the monthly weights showed the last measured weight for resident #053 prior to the March 2017 was December 2015. In December 2015, resident #053 weighed approximately several kilograms higher.
During an interview with the Administrator in May 2017, it was shared the home purchased a new scale and a weight clinic was initiated in March 2017. It was identified that if residents could not be weighed using the bath chair scale a weight was not taken.
In an interview with the RD in May 2017, it was confirmed that resident #054 had no measured weights between December 2015 and March 2017.

C) Resident #055 was at high nutrition risk and had a BMI, which was defined as "severely underweight". Resident #055's weight was low in April 2017.
A review of the monthly weights showed the last measured weight for resident #055 prior to March 2017 was March 2015. In March 2015, resident #055 weighed approximately eight kilograms higher.
During an interview with the Administrator in May 2017, it was shared the home purchased a new scale and a weight clinic was initiated in March 2017. Prior to this, it was identified that if residents could not be weighed using the bath chair scale a weight was not taken.
In an interview with the RD in May 2017, it was confirmed that resident #055 had no measured weights between March 2015 and March 2017.

The home failed to ensure that the Nutrition and Hydration program included monthly weights for resident #053, #054 and #055.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by physical device under section 31 or section 36 of the Act;
1. Staff applied the physical device in accordance with any manufacturer's instructions.

Resident #027 was observed on a specific date in May 2017, in a mobility device in the upright position with a physical device in place. The physical device was fastened but loose. The resident's family member confirmed the resident was unable to release the physical device. The physical device was further observed over a period of several hours on three occasions in May 2017, fastened but loose to the breadth of five fingers

between the physical device and the resident.
The resident was assessed as high risk for falls. The resident had four falls in April 2017 as a result of leaning forward in their mobility device.
The home's policy called "Restraint Program", Index: CPM-E-20, and revised January 2017, directed staff to apply a restraint in accordance with the manufacturer's instructions.
Interview of PSW #132 and #133, told the LTCH Inspector #640 that the physical device should be tighter to the depth of one flat hand between the physical device and the resident. They also confirmed the resident was unable to release the physical device.
Interview with RPN #131, confirmed the physical device was a restraint and they identified the physical device once tightened, loosened on its own. RPN #131 was unable to locate the manufacturer's instructions for the physical device.
Interview with RN #106 and PSW #138, confirmed the physical device was applied to prevent the resident from falling.
The Director of Care (DOC) and the Assistant Director of Care (ADOC) were interviewed and confirmed the home did not have the manufacturer's instructions for the physical device in place for resident #027.
During the RQI, resident #027 had been in a loaner mobility device awaiting the repair of their personal mobility device.
The home did not have the manufacturer's instructions for the loaner mobility device as confirmed by the DOC and the ADOC during interview with the LTCH Inspector.

The home failed to ensure that staff applied the physical device for resident #027, in accordance with any manufacturer's instructions.

2. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act; (2) The physical device was well maintained.

Resident #027 was observed in a mobility device in the upright position with a physical device in place and fastened on a specific date in May 2017. The physical device was also observed on three occasions in May 2017, fastened but loose to the breadth of five fingers between the physical device and the resident. The resident's family member confirmed the resident was unable to release the physical device.
The home's maintenance log was reviewed and there was no documentation to reflect that the staff had reported the loose physical device so that it could be repaired or replaced.
Interview of PSW #132 and #133, told the LTCH Inspector the physical device should be

tightened to the depth of one flat hand between the physical device and the resident, and confirmed the resident was unable to release the physical device.
Interview with RPN #131 confirmed the physical device was a restraint as the resident was unable to release the device. The RPN also confirmed that the physical device should have been tightened to one flat hand between the resident and the physical device. The RPN identified the physical device once tightened, loosened on its own on a regular basis but they had not reported it for repair/replacement. RPN #131 confirmed the physical device was not applied appropriately as it was too loose.
Interview with RN #106 and PSW #138, confirmed the physical device was applied to prevent the resident from falling as they had a history of falls.
The home did not maintain the physical device, which placed the resident in a position of falling from their mobility device.

3. The licensee failed to ensure that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Resident #027 was observed over a period of several hours on two dates in May 2017.
On a specific date in May 2017, the resident was observed over a period of several hours. During these observations the resident was not repositioned or monitored hourly. The resident was in a mobility device with a fastened physical device, leaning to the left with their head forward, they remained in the same position physically and the position of the mobility device had not changed.
The home's policy called “Restraint Program”, Index: CPM-E-20, and revised January 2017, directed staff; “Residents utilizing a restraint for any reason must have hourly monitoring and documentation”.
Review of the written plan of care revealed the task and specific interventions. Review of the clinical record, specifically Point of Care, (POC) revealed that monitoring was documented every two hours and staff were directed to release the physical device and reposition the resident at that time.
Interview of PSW #132 and #133 indicated that they monitored the resident every two hours and not every hour. The also repositioned the resident every two hours. The PSWs indicated that they may take the resident to the washroom then assist back to the mobility device and documented their action in POC.
Interview with RPN #131 indicated that resident #027 was monitored and repositioned every two hours by the PSWs and no hourly monitoring was in place.
The home failed to ensure that resident #027 was monitored at least every hour.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee failed to ensure that mobility devices, including wheelchairs, walkers and canes were available at all times to residents who require them on a short-term basis.

A) Resident #037 was dependent on a personalized device for all mobility. On a specific date in April 2017, the resident's personal mobility device broke.
During stage 1 resident interview, resident #037 told the Long Term Care Home (LTCH) Inspector #640 that the resident was upset at having to use another resident's mobility device due to their device being broken for a month.
Outside resident #037's room, on a specific date in May 2017, the LTCH Inspector observed the broken mobility device with the repair requisition dated on a specific date in April 2017.
Review of the clinical record revealed that resident #037 had been required to stay in bed for seven days until the resident received the loaner mobility device from resident #047 on a specific date in May 2017.
During an interview with RN #105, they told the LTCH Inspector that resident #037 had been using the mobility device of resident #047 for three weeks as a result of resident #037's mobility device being broken. The RN also stated that permission was received from resident #047's family to use the mobility device for another resident for a few days.

Interview with resident #047 and their family revealed that both were upset at being asked to loan out the personalized mobility device and also upset as to the length of time the mobility device had been out on loan to another resident.
Review of the contract between the home and mobility service provider, revealed the service provider willing to provide loaner equipment when required. Review of available equipment with RN #105, the Director of Care (DOC) and the Assistant Director of Care

(ADOC), they all told the LTCH Inspector the home did not have an inventory of equipment. They had one wheelchair which had been broken for several months.

B) Resident #041 was dependent on a personalized mobility device for all mobility. On a specific date in May 2017, the resident's personal mobility device broke.
The LTCH Inspector #640 observed the mobility device losing a part as staff were taking the resident into their room. PSW #101 informed the LTCH Inspector that the PSW had completed the appropriate requisition for the service provider and informed the nurse in charge. RN #105 informed the LTCH Inspector the service provider had been notified and were to attend the home that evening and bring a loaner mobility device as the home does not have an inventory of mobility devices for short-term use.
Observation of the resident by the LTCH Inspector at a specific time and date in May 2017, observed the resident to be in bed.
Interview of RPN #126, revealed knowledge of the broken mobility device and the resident would have to eat dinner in the bed. Observation of resident #041 the following day in May 2017, revealed the resident to be in bed, the mobility device not repaired and sitting in the hallway with a note attached to it. Interview with RPN #114 who told the LTCH Inspector the service provider had been in last evening. RPN #114 was not aware of why the mobility device had not been repaired or why there was no loaner as promised. RN #105 told the LTCH Inspector that the service provider had been in last evening but did not repair the mobility device or leave a loaner mobility device.
Review of the requisition for repair by the LTCH Inspector did not show any documentation to identify the service provider had been in and/or why there were no repairs completed or a loaner mobility device left for this resident. The mobility device was repaired during the last week in May 2017, by the home's service provider. The resident had remained in bed for lunch.
Review of the contract between the home and the service provider, by the LTCH Inspector, revealed the service provider willing to provide loaner equipment when required.
Review of available equipment in the home, with RN #105, the Director of Care (DOC) and the Assistant Director of Care (ADOC), they all told the LTCH Inspector the home did not have an inventory of available equipment for resident use. They had one mobility device which had been broken for several months.

The home failed to ensure that mobility devices, including wheelchairs, were available to resident #037 and #041, who required them on a short-term basis.

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: 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 failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with the Long Term Care Home Act (LTCHA)2007, s.48, which required the licensee to ensure that the interdisciplinary programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

A) The Nurse Practitioner (NP) assessed resident #027 on a specific date in May 2017, and the resident was subsequently transferred to the hospital. The NP noted the resident had elimination issues over a period of five days in April 2017.
The home's policy called "Bowel and Bladder Continence Care Program Overview", Index: CPM-B-10, and revised February 2016, directed PSWs to notify registered staff when the resident did not have a bowel movement for more than 48 hours. Registered staff were directed to review their Resident Home Area bowel/bladder records and to follow up daily and obtain and/or initiate appropriate interventions according to the

Physician/NP orders. The policy called "Bowel Protocol: Management of Constipation", revised June 2015, directed staff to initiate the protocol when there was no bowel movement outside the normal pattern for the resident.
Review of the clinical record revealed staff did not review and identify that the resident had elimination problems for six days, until the NP assessed the resident, and therefore did not implement the appropriate protocol for the resident.
Interview with RN #106 who confirmed that staff had not reviewed and identified resident #027 had elimination problems for six days. The RN also confirmed the protocol had not been initiated.
Interview with the ADOC confirmed that staff did not identify resident #027 had elimination problems for six days and the protocol was not initiated. The ADOC told the LTCH Inspector that it was the expectation of the home that PSWs notify the registered staff when the resident had elimination problems over 48 hours and registered staff were expected to review the resident's records daily and implement appropriate interventions.
The home failed to ensure that staff complied with their policies, procedures and protocols related to the care of resident #027.

B) On a specific date in December 2016, resident #048 had an unwitnessed fall and sustained an injury.
At the beginning of January 2017, the family member requested the resident to be sent to hospital due to having fallen several times in a short period of time, which resulted in an injury. Resident #048 remained in hospital and had deteriorated according to the family member.
The home's policy called "Head Injury Routine", Index: NAM-F-65 and revised February 2016, directed staff to initiate head injury routine (HIR) assessment for any unwitnessed fall to identify promptly any neurological changes. HIR was to be initiated immediately and be completed as follows; every 30 minutes for one hour, every hour for two hours, every two hours for four hours, every four hours for 24 hours and once a shift for seven days.
Review of the clinical record identified the HIR assessments to be incomplete. Immediately following the fall, the HIR assessment was initiated but did not include assessment of both pupils. A half hour later, one hour later and at bedtime the day of the fall, and just after midnight the following day, no HIR assessment was completed. There was no assessment of the pupils on nine occasions of a possible 18, eight of which were scheduled to be completed immediately following the unwitnessed fall.
Interview of RPN #152, the nurse initiating the HIR, who concluded the HIR assessments were not completed as per policy. In hindsight, the RPN stated, the HIR policy and assessments should have been followed.

During interview with the ADOC by the LTCH Inspector, the ADOC informed the LTCH Inspector the HIR policy had not been followed and in the absence of a physician's specific order for head injury routine, it was expected that the Head Injury Routine be followed as directed in the policy.
The licensee failed to ensure that the home's Head Injury Routine policy was complied with.

C) On a specific date in May 2017, resident #058 had a witnessed fall and sustained an injury.
The home's policy called "Falls Intervention Risk Management (FIRM) – Implementation", Index CPM-C-20, and revised October 2016, directed staff to complete a Post Fall Assessment in Point Click Care (PCC) and if the fall was unwitnessed or the resident hit their head, the Head Injury Routine (HIR) was to be initiated.
On a specific date in May 2017, the Nurse Practitioner was requested to assess resident #058 due to deterioration. The resident was sent to the hospital for further assessment. HIR was initiated immediately post-fall and was to be completed as follows; every 30 minutes for one hour, every hour for two hours, every two hours for four hours, every four hours for 24 hours and once a shift for seven days. Review of the clinical record identified the HIR assessments to be incomplete and documentation confusing. The clinically appropriate assessment instrument had a specific date in May 2017, and made no note of the resident's injury. The progress note in reference to a fall huddle, was dated at the beginning of May 2017, made reference to a fall with injury that occurred at that date. A head injury routine was already in place related to a fall that occurred earlier in April 2017. The vital signs and HIR were not documented for several dates and times in May 2017. A couple of days later in May 2017, there was no HIR assessment completed. The resident had a subsequent fall on a specific date in May 2017. The HIR assessment tool was initiated as per policy however, the first six HIR assessments were not documented as complete.
During an interview with the ADOC, they indicated that it was the expectation of the home that when there was an unwitnessed fall and/or a head injury, the HIR was to be completed as directed by the policy unless there was a subsequent physician order with directions other than the ones included in the HIR policy. In this case, there were none.
During an interview with the Administrator, the Administrator indicated that it was the expectation of the home that the policy for falls prevention, which included directions for the initiation of the Head Injury Routine, were to be followed as written in the policy.
The licensee failed to ensure that the home's policy for Head Injury Routine was complied with.

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

During the initial stage of the RQI, three call bells were found to be not working. One call bell wass inaudible at the end of the hallway; however the light did activate outside the door to the room. The call bell in a shared washroom of room was non-functional as the string was broken between the pull cord and the activation lever. Four residents shared this washroom. The bedroom call bell another room did not function when the call bell was pushed. There were no lights or sound after several attempts.
The home's policy called "Communication & Response System (Call Bells)", Index: NAM-J-90, and revised October 2016, directed staff to ensure the communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.
The "Tyndall Nursing Home Check List – Call Bells" directed staff to ensure call bells were functional at the bedside and in the washroom by checking each call bell weekly by the Team Leader.
The "Nursing Administration - Job Routine - HCA", reviewed October 10, 2009, directed staff to check call bell to ensure they were functional, accessible and cords were in good condition.
Review of the checklists revealed that the call bells on one of the units had not been checked from January 2017, to the date of inspection in May 2017. The call bells on another unit had been checked and documented as functional up to May 16, 2017, the day of the inspection.
Interview with the DOC and the ADOC identified that the call bells on the unit had not been checked as per the home's policy and process for two months.
The call bells in three rooms were not able to be used by residents, staff and visitors at all times as they were found to be non-functional.

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 ensure that the home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, was immediately investigated.

Resident #009 reported to LTCH Inspector #561 an allegation of staff to resident abuse on a specific date in May 2017. The LTCH Inspector immediately reported this to the Administrator of the home with consent of the resident. Resident #009 confirmed that the home was not aware of this incident they had shared with the LTCH Inspector.
On a specific date in June 2017, the LTCH Inspector asked for copies of the investigation notes and the ADOC confirmed at that time that the investigation of this incident had not been initiated. The Administrator subsequently commenced the investigation in June 2017.
The home failed to ensure that the allegation of abuse from staff towards resident #009 was immediately investigated.

2. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A) The critical incident report submitted to the Director on a specific date in March 2017, indicated that there was an allegation of physical abuse by PSW #153 towards resident #052. The critical incident report was reviewed by the LTCH Inspector #640, and during the inspection the review of clinical records revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.
The ADOC and the Administrator were interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed.

B) The critical incident report submitted to the Director on a specific date in October 2016, indicated that there was an allegation of physical abuse by resident #005 towards resident #049. The critical incident report was reviewed by the LTCH Inspector #561, and during the inspection the review of clinical records revealed that the home did not amend the critical incident report with the results of the investigation and did not submit this information to the Director.
The Administrator was interviewed and confirmed that the results of the investigation were not reported to the Director after the investigation was completed.

The home failed to ensure that the results of the abuse investigations for resident #052 and #049 were reported to the Director.

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, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, and ensure that the licensee reports to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the

suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home's policy called "Abuse and Neglect", Index: NAM-B-20, revised July 2015, was reviewed and directed "staff and board members must immediately report every alleged, suspected, or witnessed incidents of abuse of a resident by anyone".

A) The incident of alleged physical abuse of resident #051 by resident #009, occurred on a specific date and time in October 2016. The Director was notified via the ActionLine but not until twenty four hours after the incident occurred.
The critical incident report was subsequently submitted to the Ministry of Health and Long Term Care (MOHLTC) on several days later in October 2016.
The DOC and ADOC were interviewed and confirmed that they did not report the critical incident until immediately to the Director and were aware that they were expected to immediately report the alleged physical abuse.

B)The incident of alleged physical abuse of PSW #153 towards resident #052 occurred on a specific date and time in March 2017. The Director was not notified until approximately nineteen hours after the alleged abuse occurred.
During an interview, RN #155 confirmed that the Director of Care (DOC) was informed of the incident after it occurred.
The DOC and the ADOC were interviewed and confirmed that the critical incident report was delayed in being submitted to the MOHLTC when they knew that they were expected to report the alleged abuse immediately to the Director.

C) Resident #046 was exhibiting identified behaviours on a specific date in November 2016, towards resident #045. Resident #046 was observed by staff exhibiting the behaviours towards resident #045. Staff identified during interviews that resident #046 would exhibit identified behaviours towards resident #045. In addition, this was the second incident involving resident #046 being abusive towards resident #045.
The home did not notify the Director of the alleged sexual abuse until a specific date in November 2016, which was over twenty four hours after the incident occurred.
The DOC and ADOC were interviewed and confirmed that they did not report the critical incident until a specific date in November 2016. They also confirmed that they knew they were expected to report any suspected, alleged or actual abuse to the Director immediately.

The home failed to ensure that the alleged abuse of resident #045, #051 and #052 was reported immediately to the Director.

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 person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #043 had a history of responsive behaviours, as well as identified behaviours were exhibited in January and September, 2016. The identified behaviours exhibited occurred on a specific date in September 2016, whereby resident #043 and #044 were observed by the staff exhibiting inappropriate behaviours.
The home's policy called "Responsive Behaviours Program Overview", number SP-B-10, with an effective date of January 2014, directed staff to document "Individual Resident: assessment, interventions, resident's response to the interventions, reassessment, plan

of care revisions, flow sheets."
The resident's clinical record was reviewed and revealed that there was incomplete documentation of the Behavioural SBAR-Huddle Communication Tool. There was no documentation on the SBAR Huddle related to recent medication changes; the resident's history of illness and related factors; assessment information such as vital signs, environmental and social factors; and there was no recommendations or interventions identified. In addition, the Dementia Observational System (DOS) documentation for a period of six days in September 2016, was incomplete. There were five shifts where the PSWs did not document any resident responses for resident #043 and #044.
The DOC and the ADOC were interviewed and confirmed that the PSWs were expected to document every 30 minutes for each shift, the observed behaviours of resident #043 and #044, and the charge nurse on duty on a specific date in September 2016 was expected to complete the Behavioural SBAR-Huddle Communication Tool.
The home did not ensure resident #043's responses to interventions were documented in their clinical health record. (527)

B) On two specific dates in December 2016, resident #048 sustained three falls. The first fall was unwitnessed by staff and the resident was injured. There were susbequently two more falls in December 2016, both of which were witnessed and documented as no injury.
The "Fall Incident Initial Post-Fall Assessment 2014 (SVCH)" documents were completed as per the home's policy "Falls Intervention Risk Management (FIRM) – Overview", Index: CPM-C-10, and revised October 2016. Within the documents on all three occasions, in the "Describe immediate action taken" free text box, RPNs #139, #152 and #158 all documented that a head-to-toe assessment had been completed.
Interview with RPNs #139 and #152, who told the LTCH Inspector that the head-to-toe assessment they had done, was completed in a head-to-toe assessment located in the Assessment tab in Point Click Care (PCC) documentation tool.
The Long Term Care Home (LTCH) Inspector#640 reviewed the clinical record in PCC and the hard copy of the clinical record. There were no head-to-toe assessments located in PCC or in the hard copy of the clinical record. The LTCH Inspector sought the assistance of the RAI-MDS Coordinator to locate the head-to-toe assessments as stated by the RPNs. The RAI-MDS Coordinator confirmed there were no head-to-toe assessments for any of the falls for resident #047.
Interview with the ADOC confirmed the head-to-toe assessments were expected to be completed in the head-to-toe assessment form within the Assessment tab in PCC and they were not completed in PCC as expected.
The home failed to ensure that any actions taken with respect to resident #047 under a

program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied: 1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Resident #027 was admitted to the home on a specific date in November 2016, with a mobility device in place. The mobility device prevented resident #027 from releasing the device. At that time, the home did not have a policy, process or clinically appropriate assessment tool in place for the use of any Personal Assistive Services Devices (PASD), as per the Administrator and Assistant Director of Care (ADOC).
The home implemented a policy for the use of PASDs and a clinically appropriate assessment tool for PASDs in March 2017. As a result, all residents who had a PASD in place at that time were to have the clinically appropriate assessment tool completed, which included alternatives that had been tried and their effectiveness.
The ADOC provided the Long Term Care Home (LTCH) Inspector with the list of residents with PASDs in place as of March 2017, which the home used to complete the PASD assessments. Resident #027's name was not on the list.
Interview of the DOC and the ADOC confirmed the resident did not have the assessment that included alternatives to the use of the PASD tried, prior to implementation of the mobility device.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers,skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

As a result of an unwitnessed fall on a specific date in December 2016, resident #048 was injured.
The home's policy called "Assessment and Management - Skin Conditions", Index: CPM-F-30, and revised October 2016, directed staff to assess skin tears initially and for subsequent re-assessments on the "Skin Tear Assessment" tool.
Review of the clinical record by the LTCH Inspector #640 revealed the required skin assessment was not completed by the nurse.
Interview with RPN #152 confirmed there was no assessment completed for the resident as a result of the fall.
Interview with the ADOC confirmed a specific assessment was required to be done for the resident as per the home's policy.
The home failed to ensure that resident #048 had an assessment of the injury by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #15: 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,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (c) each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Resident #009 had a plan of care indicating that they were incontinent and wore a product; however the resident knew when they needed to void and required assistance with two staff for toileting. Furthermore, the plan of care indicated that resident was on routine toileting, and staff were to check and toilet the resident after meals, when the resident asked and as needed. A specific lift was used to transfer the resident.
Resident #009 was interviewed on two specific dates in May 2017, and on both occasions the resident stated that the staff did not place them on the toilet when they needed to go and they only took them to the bathroom once a day. The resident further stated that during the remainder of the day they had to use their product because the PSW staff were telling them they did not have time to take the resident to the bathroom.
During an interview, PSW #143 indicated that the resident was incontinent. Resident was on a toileting schedule and was to be toileted every morning, before lunch and after lunch. The PSW stated that the resident was not able to say whether they needed to go to the bathroom.
PSW #145 stated that the resident was incontinent and was not able to say whether they needed to go to the bathroom and used their brief. The PSW stated that the resident was not on a toileting plan and they did not often place the resident on the toilet.
The ADOC was interviewed and confirmed that the resident was able to identify the need to be toileted and the plan reflected this. The ADOC also stated that they talked to the PSW staff and they confirmed that the resident was toileted, and the staff would wait until the resident asked. The ADOC confirmed that the resident did not receive the assistance from staff to manage and maintain continence.

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, (c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On a specific date in December 2016, resident #048 required medication for pain as a result of an unwitnessed fall that occurred on that same date.
The fall incident note completed by RPN #152, concluded the resident was in pain as a result of the fall. The following days the resident required medication for the same pain. The documentation, included the resident was to go out of the home but was unable to due to pain.
The home's policy called "Pain Assessment and Symptom Management Implementation", Index; CPM-D-20, and revised October 2016, directed staff to complete a pain assessment with any identified alteration of the resident's pain processes, with the initiation of pain medication; when pain medication was administered as needed (PRN), or when there was a sudden onset of new pain.
There was no pain assessment completed for this resident related to the sudden onset of new pain, the initiation of PRN analgesic and alteration of the resident's pain processes related to the pain resulting from the unwitnessed fall.
Interview with the ADOC confirmed there was no pain assessment completed as required by the home's policy.
The home did not assess resident #048's pain using a clinically appropriate assessment instrument specifically designed for this purpose.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. **A change of 5 per cent of body weight, or more, over one month.**
2. **A change of 7.5 per cent of body weight, or more, over three months.**
3. **A change of 10 per cent of body weight, or more, over 6 months.**
4. **Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. The licensee failed to ensure that residents with weight changes that compromised their health status were assessed using a multidisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #053 was at high nutrition risk and had a Body Mass Index (BMI), which is defined as "very severely underweight".
Resident #053's weight had decreased in three consecutive months in 2017.
A review of the monthly weights showed the last measured weight for resident #053 prior to March 2017, was December 2015. During the 14 month time period the resident was not weighed, their nutritional status continued to decline with an additional weight loss of greater than ten percent.
In an assessment documented on a specific date in December 2015, by RD #3, it identified that resident #053's weight represented "a severe weight loss" in one month. No actions were taken at this time as it was questioned if the weight measurement was accurate. It was identified that the plan was for the RD to reassess when resident #053 was reweighed. The resident was not reweighed until March 2017.
It was documented by RD #3 in the previous nutrition progress note on a specific date in September 2015, that resident #053's supplement was discontinued, at which time the resident's BMI revealed that they were underweight.
On a specific date in March 2016, it was documented by RD #2 that resident #053 had nutritional interventions implemented due to "high nutrition risk, and very low BMI".
In an interview with RD #1 in June 2017, the following was confirmed during a review of documentation by RD #2, RD #3 and the weight records:

i) September 2015, resident #053's supplement was discontinued because the resident's weight was stable, but the resident was underweight.
ii) December 2015, resident #053 had a significant weight loss, no action was taken, the plan was to re-weigh the resident.
iii) No measured weights were taken for the next 14 months.
iv) March 2016, a nutrition intervention was initiated, that was less dense in protein and calories than the supplement intervention previously provided

The documented weights and progress notes completed between December 2015 and March 2017, confirmed a interdisciplinary approach including the measurement of resident #053's weight was not completed, actions were not taken to prevent further weight loss and outcomes could not be evaluated.

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 residents with specific weight changes detailed in the legislation were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure residents were provided with eating aids, assistive devices, personal assistance and the encouragement required to safely eat and drink as comfortably and independently as possible.

A) Resident #054 was at moderate nutrition risk, had a recent weight loss (falling below their goal weight range) and required a texture modified diet and extensive assistance from one staff with eating.
During a lunch observation on a specific date and time in May 2017, resident #054 did

not eat anything and was not offered assistance with their meal. Approximately forty-five minutes later a PSW asked the resident if they were finished and the resident responded "yes". The staff began to remove the resident's meal at which time LTCH Inspector #583 requested that they leave the residents plate and requested the RD come to the dining room. At this time RPN #115 began providing extensive feeding assistance, which resident #054 accepted and began eating well, completing their meal.
In an interview with the RD and the Food Service Manager (FSM) it was confirmed that resident #054 required extensive assistance with eating and that the home failed to provide the resident with the personal assistance and encouragement required to eat and drink.

B) Resident #009 was at high nutrition risk and was assessed to require an eating aid to assist with their ability to feed themselves.
During an observation in May 2017, resident #009 received their main meal without the eating aid. Resident #009 was able to feed themselves but some of the food fell off the plate onto the table.
In an interview with the FSM on the same date in May 2017, it was confirmed that resident #009 did not receive the eating aid as required to eat as independently as possible.

2. The licensee failed to ensure residents were provided with appropriate furnishings and equipment in the dining area, including dining room tables at an appropriate height to meet the needs of all residents.

A) Resident #017 was observed during on two specific dates and times in May 2017. They received a texture modified diet and required extensive assistance with cueing and some physical assistance during the service. The resident was seated in their mobility device at the table. Resident #017's torso was greater than 30 centimetres from the table. The resident was observed to have difficulty throughout the meal reaching their food on the table. On a specific date in May 2017, it was confirmed with the PSW that the resident's positioning at the table could not be improved due to the table height, table leg and the structure of the resident's mobility device.
In an interview with the FSM and RD on the same date in May 2017, it was identified that resident #017 could not be brought in closer to the table, confirming the resident's needs were not being met in the dining room with the current furnishings.

B) Resident #057 was observed during meal service on two specific dates in May 2017. They received their a meal with modified texture food. Resident #057 was impaired

physically and was observed to require extensive assistance during the meal service from staff. The resident was seated in their mobility device at the table. Resident #057's table height was at an appropriate height for the resident. The resident was observed to be unable to reach or find the food on their own without staff assistance. The resident was observed to have periods of greater than 15 minutes with food placed in front of them without staff assistance.
In an interview with the FSM and RD on a specific date in May 2017, it was identified that resident #017 could not reach their food or beverages and could not identify where items were with the inappropriate table height, confirming the resident's needs were not being met in the dining room with the current furnishings.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that their drug destruction and disposal policy included that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

The home's policy called "Surplus and Discontinued Narcotic and Controlled Medications", Index: 6-7, and reviewed March 2016, indicated that "when a narcotic or controlled medication is discontinued it must be removed from the med cart and given to the DOC or placed in the narcotic drop box".
Interview with RPN #124 indicated that if a medication was being discontinued on the weekend it was kept in the bin in the medication cart along with other narcotics that were being administered to residents until the DOC came in on Monday.
In June 2017, the DOC confirmed that the staff would bring the discontinued medications to the DOC and the DOC placed the discontinued and controlled substances in the bin that was kept in their office. If a medication was discontinued on the weekend, registered staff would place it in the the bin in the medication cart with other like medications that were administered to residents until the DOC's next shift.
The home's "Surplus and Discontinued Narcotic and Controlled Medications" policy did not state that the controlled substance that was to be destroyed shall be stored in a double-locked storage area separate from any controlled substance that was available for administration to a resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the drug destruction and disposal policy must also provide for the following: 2. That any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered at each meal.

A) During an observation on a specific date and time in May 2017, resident #027 was not offered specific juice. The resident's planned menu developed by the RD identified the resident was to have the specific juice at two out of the three meals each day.
In an interview with the FSM on a specific date in May 2017, it was confirmed that resident #027 was not offered their planned juice at one of the meals.

B) During another observation on a specific date and time in May 2017, resident #017 was not offered their nutritional interventions. The resident's planned menu developed by the RD identified the resident was to have the nutritional intervention for added calories and protein.
In an interview with the FSM on a specific date in May 2017, it was confirmed that resident #027 was not offered their planned nutritional intervention at one of the meals.

Issued on this 4th day of October, 2017

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) :	KATHLEEN MILLAR (527), BERNADETTE SUSNIK (120), DARIA TRZOS (561), HEATHER PRESTON (640), KELLY HAYES (583)
Inspection No. / No de l'inspection :	2017_544527_0007
Log No. / No de registre :	009294-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 22, 2017
Licensee / Titulaire de permis :	TYNDALL NURSING HOME LIMITED 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
LTC Home / Foyer de SLD :	TYNDALL NURSING HOME 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patricia Bedford

To TYNDALL NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

1) The licensee shall develop and implement a procedure to notify all existing and new residents regarding the provision by the staff of the home, of basic foot care to include the trimming of toenails.
2) The licensee shall keep a record of the notification and the choice made by each resident/Substitute Decision Maker (SDM) regarding basic foot care services.
3) The licensee shall document the choice for each resident, new or existing, within the plan of care for that resident and immediately implement the choice as identified by the resident.
4) For every resident that has paid for the contracted service for basic toenail care prior to this inspection, the licensee shall reimburse total/full charges paid (fees paid to the home including fees forwarded to the contracted service provider) since the date of the residents admission.
5) Notify and explain the reason for the reimbursement of charges for toenail care and include the name of the individual (resident/SDM) to whom this discussion was provided to and documentation in the clinical record.
6) Obtain signature of receipt of total fees reimbursed to each resident.
7) Include details on admission and in the admission package related to basic toenail care, and outline the procedure and any related costs for advanced foot care.
8) The licensee shall ensure that nursing staff are trained in the required provision of basic foot care to include the trimming of toe nails and the expectation of this provision.

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home received

preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

2. The Order is made based upon the application of the factors of severity (3), scope (2) and compliance history (2), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #047 experienced, the scope was a pattern, and the Licensee's history of noncompliance.

3. During interview of resident #047, the Long Term Care Home (LTCH) Inspector #640 noted the resident's toe nails to be long with debris on them.
The clinical record revealed the resident had signed a consent for podiatry services to be provided every four to six weeks but the resident was not included on the podiatry services list.
The written plan of care directed staff to trim finger and toe nails on bath days as needed.
Review of the home's policy called "Personal Hygiene & Grooming", Index: NAM-K-01, and revised May 2016, directed staff that nail care was to be completed during the bathing routine and at other times as needed. "This may include but not limited to: trimming and cleaning".
Resident #047 was observed in bed in June 2017 with their toenail impaired.
Registered nurse (RN) #105 was interviewed and confirmed the resident's toenails were not trimmed and should have been. The RN told the LTCH Inspector the home does not provide any toenail care or trimming and that only the podiatrist does the toenails. Review of the PSW documentation with the RN demonstrated the resident's toenails had been trimmed on three occasions; the RN informed the LTCH Inspector that they could not have been trimmed as the home staff does not provide toenail care to the residents.
The Resident Services Coordinator (RSC) was interviewed and they indicated that the home does not provide any form of toenail care to the residents.
Interview of resident #047 and family revealed that they were not aware that the home could provide basic toenail care at no charge.
Interview of resident #016 revealed that they were not aware that basic toenail care could be provided by the home at no charge. The only offer for toenail care was the podiatrist at an extra cost to the resident. The resident stated they would prefer that, as would their power of attorney for finances as they found the fees an added burden of expense.
Interview with resident #036 also revealed that they were not aware the home could provide basic toenail care at no extra charge. During the admission process, the resident was not offered the option. They had been told about the

podiatry service only and had to sign the contract for the service and pay the fees. The resident went on to say they believed other residents' were also not aware.
The Administrator told the LTCH Inspector they were not aware the home did not provide basic toenail care to residents and the home was required to provide and offer basic toenail care at no cost to the resident.

The home failed to ensure that resident #016, #036 and #047 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

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. 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 complete the following:

1) Ensure residents #020, #045 and #052 are protected from physical, sexual and emotional abuse by anyone.
2) Ensure that interventions are implemented to manage resident #046, who exhibited sexually responsive behaviours.
3) Implement an auditing process to ensure that residents who exhibit sexual responsive behaviors are re-assessed, new interventions initiated and the plan of care revised.
4) Provide all staff with retraining on the home's prevention of abuse policy and legislation that promotes zero tolerance of abuse and neglect of all residents by anyone.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and failed to ensure that residents were not neglected by the licensee or staff.

2. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the actual harm that resident #052 and #020 experienced, the scope of three incidents, and the Licensee's history of noncompliance (VPC) on March 30, 2016, issued as a result of a critical incident inspection.

3. A) The critical incident report submitted to the Director in March 2017, indicated that there was an incident of alleged physical abuse that occurred in March 2017, by PSW #153 towards resident #052.
The investigation notes indicated that in response to the resident's responsive

behaviour, the physical actions taken by PSW #153 to respond to the resident's behaviour.
RN #155 witnessed the incident and told the PSW to stop; however the PSW said that they could not. The RN stepped in between the PSW and the resident to de-escalate the situation.
Resident #052 was interviewed and was able to recall some of the details of the incident. They stated that they remembered the PSW and what they had done. The resident stated that the PSW caused pain and this was not the only thing the PSW had done; resident stated that they hit them and twisted their finger. The resident became teary and stated that they were afraid of PSW #153.
During an Interview, RN #155 indicated that in March 2017, they came off the elevator on the third floor and observed registered staff and PSWs standing at the nursing station and heard someone yell. Another registered staff indicated that it was resident #052. RN #155 went to see what was happening and when they entered the room they saw how PSW #153 was treating the resident. The resident sustained an injury and indicated that they were in pain. The RN stepped in and told the PSWs to leave.
RN #155 further indicated that the way the PSW was treating the resident during the incident was unacceptable, instead of calling for help when the situation escalated and leaving the resident alone, PSW #153 was provoking them and was yelling back at the resident.
During an interview, PSW #153 stated that the resident was agitated and they had to prevent the resident from hitting them. PSW #153 indicated that during the incident they did not believe there was any harm done to the resident. The PSW stated that the resident was used to situations like this as this was not the first time they had such behaviours.
During an interview, PSW #154 stated that the resident was having behaviours and they acted in a way, which caused no harm to the resident. PSW #154 denied that PSW #153 was rough with resident #052 or yelling at the resident. PSW #154 indicated that they should have gone to get help to de-escalate the situation.
The investigation notes indicated that PSW #153 received disciplinary action for the way they handled the situation.
The ADOC and DOC confirmed that the actions of PSW #153 were abusive towards the resident. (561)

B) During stage 1 of the Resident Quality Inspection (RQI), resident #020 told the Long Term Care Home (LTCH) Inspector #640 that PSW #117 provided care forcefully despite the resident telling the PSW not to do so. The resident

that they yelled at the PSW to stop but the PSW continued. The resident shared with the LTCH Inspector the staff member had been moved to another area in the home. If the person were to work with them again or be seen by them, they would be very frightened. Resident #020 documented the incident in their own hand writing, that included the date of the occurrence in February 2017.
Review of the clinical record identified the resident's family member called the home in February 2017, after the incident, to inform the home of the note they had received from the resident, regarding the incident. The family member lodged a complaint with the Ministry of Health and Long Term Care (MOHLTC) in February 2017. The home submitted a critical incident report to the Director the following day.
Interview with PSW #117, revealed the resident required specific care and they told the LTCH Inspector the resident did not scream or yell.
Interview with RN #149, the nurse in charge during the shift, who told the LTCH Inspector the resident did not want to have care but the RN had talked them into it. The RN stated they did not hear anything during the resident's care as they were not on the unit.
The DOC confirmed that the care provided to resident #20 by PSW #117, was a form of abuse of the resident. The PSW was disciplined, was required to complete re-education about abuse and neglect, and was permanently transferred to another home area to work as a result of the incident. (640)

C) Resident #046 was known to staff to exhibit sexual responsive behaviours. These behaviours were primarily targeted at resident #045. Strategies were developed and implemented; however the resident was known to remove any door barrier and subsequently this intervention was assessed as being ineffective and discontinued. A number of other strategies were developed and implemented to manage the resident's behaviour. The home transferred resident #046 from one floor to another in December 2016. Although resident #046 was transferred to another resident care unit, resident #046 continued to exhibit sexual responsive behaviours to other residents.

(i) In May 2016, staff observed resident #046's exhibiting sexual responsive behaviours to resident #045.

(ii) In November 2016, resident #046 was observed by staff exhibiting sexual responsive behaivours to resident #045.

(iii) In December 2016, resident #046 was trying to call resident #045 to their

room and exhibiting sexual responsive behaviours to resident #045's. Staff reminded resident #046 not to touch another resident in a sexual manner. In addition, resident #046 was observed by staff when they removed the barrier from their room, stayed by the doorway and trying to call resident #045 to their room.

(iv) In December 2016, resident #046 was observed by staff when they tried to remove the door barrier again from their room, and later on the same day they were observed by staff trying to call resident #045 to their room.

(v) Again, in December 2016, resident #046 was observed signalling to a co-resident to go towards another area of the unit. The staff subsequently heard the two residents talking. Resident #046 was told by staff to leave the other resident alone.

(vi) In January 2017, resident #046 was seen by staff exhibiting sexual responsive behaviours towards resident #052 and the residents had to be separated.

Resident #046's clinical record was reviewed, staff to resident and resident to resident interactions were observed throughout the RQI, and staff were interviewed. The clinical record revealed that there were no referrals to the Psychogeriatric Resource Consultant (PRC), which the home would do if the responsive behaviour strategies were ineffective, and as an additional resource to assist in managing the resident's responsive behaviours. There was no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessments conducted since May 2016. The Behavioural Support of Ontario (BSO) RPN #157 had indicated in their documentation that they would conduct a PIECES assessment; however this was also not completed for resident #046.
The BSO RPN #139 and PSW #127 were interviewed and confirmed that the DOS charting of the resident's behaviour for seven days was expected to be completed by the staff after the November 2016, incident in order to determine if there was a pattern and a frequency to the resident's behaviour, and they were unable to locate the documentation. The BSO staff confirmed that based on their clinical pathway for responsive behaviours, the BSO should have conducted a P.I.E.C.E.S. assessment and refer to the PRC for assessment, but neither were done.
The DOC and ADOC were interviewed and confirmed that there were no

referrals to PRC, when there should have been and the P.I.E.C.E.S. assessment by their previous BSO was not completed to assist in managing the resident's responsive behaviours. The DOC and ADOC confirmed that resident #046 had sexual responsive behaviours prior to and after the critical incident in November 2016, with the same resident #045, and subsequently with other residents on another floor. The DOC and ADOC confirmed that resident #046 was moved to another unit as one intervention to manage their sexual responsive behaviours towards resident #045; however this strategy was not implemented until the first week in December 2016, and subsequently resulted in resident #046 continuing to exhibit sexual behaviours towards other residents on the new unit and was not effective.
The ADOC and the BSO staff confirmed that the strategies implemented for resident #046 were to not only manage this resident's sexual responsive behaviours, but to prevent these behaviours from continuing towards female residents. They confirmed that the strategies were not effective in protecting other residents.
The home failed to protect residents from resident #046's sexual responsive behaviours.

The home failed to ensure that resident #020, #045 and #052 were protected from abuse by anyone. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2016_467591_0010, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1) Ensure the care set out in the plan of care is provided to residents as specified in the plan: Resident #041 related to fall interventions; Resident #037 related to use of their mobility device; Resident #005 related to physician orders; and Resident #047 related to bed rail use.
2) Educate all staff that are involved in the provision of care on the home's policies and procedures related to the use of the plan of care, how to the plan of care of care is revised and ensuring the care set out in the plan is provided to each resident as specified in their plan.
3) Develop and implement an auditing process to improve and ensure compliance with the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

2. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (5), in keeping with s.299(1) of the Regulation. There was potential for harm to residents, the scope was a pattern, and the Licensee's history of noncompliance (CO) on the August 31, 2016 Resident Quality Inspection with the s. 6 (7) related to the dietary and snack services. There was also noncompliance with s. 6 (7) on March 31, 2016 (VPC); on April 21, 2015 RQI (CO) and on February 4, 2014 RQI (VPC).

3. A) Resident #041 had a plan of care indicating that they were at high risk for falls and required to have a specific falls prevention strategy implemented at all times. The resident was observed in May 2017, sitting in a specific type of chair in the hallway and the falls prevention device was not working correctly. The device was checked and was not properly attached to the device. The device was turned off. PSW #134 checked the device and confirmed that it was not turned on. The PSW confirmed the resident should have had the falls prevention device on and functioning at all times. Interview with the RN #135 confirmed that the device should have been on at all times and functioning. (561)

B) The plan of care for resident #005 was reviewed and indicated that the physician ordered staff to collect a sample for testing at the beginning of February 2017.
The clinical record was reviewed and there was no evidence that the staff collected the sample or tried to collect the sample as ordered by the physician. The progress note on a specific date in February 2017, stated that on that day the staff were unable to collect the sample from the resident. The communication book for the physician was reviewed and no evidence was found that staff documented whether they tried to collect the sample during the first week of February 2017.
Interview with the RN #107 indicated that when there was a physician's order for the sample, the staff would try to collect in the evening of the day that it was ordered and if resident refused or staff were unable to collect the sample this should have been documented as such in the progress notes.
The RN reviewed the clinical record and confirmed that the sample was not collected and staff did not try until four days after the physician ordered the sample for testing. (561)

C) Resident #037 was interviewed and informed the LTCH Inspector #640, that their mobility device had been broken for approximately one month and they were having to eat all their meals in bed.
When the resident's clinical record was reviewed, the LTCH Inspector noted that on a specific date in April 2017, part of resident #037's mobility device fell off. The progress notes identified on four dates in April 2017, the resident had been kept in bed due to the broken mobility device. The resident's written plan of care directed staff that the resident was to eat all meals in the dining room.
Interview with PSW #101 and #102, who both told the LTCH Inspector #640, that resident #037 had remained in bed for several days. Interview with RN #105 and RPN #115, who both confirmed the resident had been bedridden. They also

confirmed that resident #037 normally would be up in their mobility device for the day. The resident ate meals in bed and was left socially isolated in their room as a result of being bedridden.
RN #105 and the DOC were interviewed and confirmed that it was the expectation of the home that all residents were to be assisted out of bed at their preferred wake time and taken for all meals unless contraindicated due to illness. (640)

D) LTCH Inspector #640 interviewed resident #047 in the presence of their family regarding a concern about care provided to the resident. During the discussion, the resident and their family told the LTCH Inspector the resident preferred that both bed rails be in a certain position when the resident was in bed to assist resident when staff provided repositioning every two hours.
The resident was observed multiple occasions with the bed rails down. Further observation in May and June 2017, saw the bed rails to be down while the resident was in bed.
Review of the written plan of care dated March 2017, directed staff that both the bed rails were to be in the up position for bed mobility.
Interview with PSW #125 revealed that staff did not put the bed rails up when the resident was in bed. Interview with RPN #114 confirmed that resident #047 was not to have the bed rails up. Interview with RN #105 revealed the resident was not on the list of residents using bed rails, had a "no side/bed rail" logo above the bed yet when the RN reviewed the written plan of care, they identified that both rails were to be in the up position when resident in bed. They confirmed the bed rails had not been used and they should have been in the up position to assist with bed mobility. RN #105 confirmed the plan of care was confusing and not consistent, integrated or complemented each other. (640)

The home failed to ensure that the care set out in the plan of care was provided to resident #005, #037, #040 and #041, as specified in the plan.
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee shall do the following:

1. The licensee shall ensure that residents #007, #020, #043, #046 and #061 are assessed in relation to demonstrated responsive behaviours, triggers are identified where possible and strategies are developed and implemented to respond to these responsive behaviours.
2) (a) Train registered staff on the factors, approaches, screening protocols, and assessments to identify behavioural triggers that may result in responsive behaviours.
(b) Train registered staff on the resources/expertise available and referral protocols for internal and external experts to assist with the management of residents with responsive behaviours.
(c) Train direct care providers on the strategies, which includes techniques and interventions, to prevent, minimize or respond to the responsive behaviours of residents.
(d) Ensure that direct care providers are trained on the responsive behaviour evidence-based clinical pathway and staff are compliant with the pathway.
3) Implement a system to ensure the responsive behaviour program meets the legislative requirements, evaluates resident outcomes, and the effectiveness of the program to improve the quality of care provided and minimizes/mitigates the risk to residents.

Grounds / Motifs :

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

2. The Order is made based upon the application of the factors of severity (3), scope (3) and compliance history (4), in keeping with s.299(1) of the Regulation. There was harm to residents, the scope was a widespread especially related to 53 (4) c, and the Licensee's history of noncompliance (VPC) on the August 31, 2016 Resident Quality Inspection; (VPC) March 30, 2016 and (VPC) April 21, 2015.

3. A) Resident #043 had a history of responsive behaviours, as well as sexual behaviours which were exhibited in January and September, 2016. The sexual behaviours exhibited by resident #043 occurred in September 2016.
The clinical record was reviewed and based on the RAI-MDS in November 2016, the resident's behavioural symptoms had deteriorated since the previous assessment in September 2016, related to the resident being resistant to care.
The written plan of care dated November 2016, identified that the resident had a history of an identified behaviour towards a co-resident. There was no date or identification of which co-resident the written plan of care was referring to, and there was no behavioural triggers identified. The "Behavioural SBAR (Situation, Background, Assessment and Recommendations) - Huddle Communication" Tool was reviewed and it did not include any triggers.
RPN #126 was interviewed in June 2017, and they were not aware of the triggers that caused the resident's sexual behaviours in September 2016. The RPN shared that they felt that it was the other resident #044 who initiated the sexual activity.
BSO RPN #139 and BSO PSW #144 were interviewed and they were not aware of what the triggers were for resident #043's sexual behaviours and indicated that this would be identified when the interdisciplinary team conducted the Behavioural SBAR Huddle. The Behaviour SBAR Tool was reviewed by the BSO staff and they indicated that it was incomplete. The BSO staff indicated that when the triggers were identified for residents with responsive behaviours, then the team was able to individualize the strategies to manage the behaviours.
The DOC and ADOC were interviewed and they were not aware of the triggers for resident #043's sexual behaviours and were unable to find the triggers on the resident's clinical record. (527)

B) Resident #046 was exhibiting sexual responsive behaviours and on a specific date in November 2016, the resident was observed by staff exhibiting sexual behaviours towards resident #045.
The resident's clinical record was reviewed and based on the "Behavioural SBAR (Situation, Background, Assessment and Recommendations) - Huddle Communication" Tool there were no behavioural triggers identified; however it did indicate that the resident had a history of inappropriate sexual behaviours related to touching and kissing another resident. There was also no Physical, Intellectual, Emotional, Capabilities, Environmental and Social (P.I.E.C.E.S.) assessment completed on the clinical record, which would have assisted in identifying behavioural triggers.
The BSO RPN #139 and PSW #127 were interviewed and confirmed that based on their clinical pathway for responsive behaviours, the team conducts the SBAR Huddles and that helps to identify triggers for behaviour and that the BSO would usually conduct a P.I.E.C.E.S. assessment to assist the team identifying behavioural triggers.
The DOC and ADOC were interviewed and they confirmed that they did not know what the behavioural triggers were for the resident's responsive behaviours and were unable to locate any information related to triggers on the resident's clinical record and in discussion with their staff. The DOC and ADOC confirmed that the SBAR Huddle tool was incomplete and did not assist in identifying behavioural triggers, and there was no P.I.E.C.E.S. assessment, which would have also assisted in identifying the behavioural triggers for resident #046.

C) The RAI-MDS quarterly assessment dated May 2017, for resident #061 indicated that the resident had physically abusive behavioural symptoms and this behaviour occurred one to three days in the last seven days. This was a change in behavioural symptoms and the resident deteriorated. The previous RAI-MDS assessment dated March 2017, resident had no behavioural symptoms identified.
The Resident Assessment Protocol (RAP) dated May 2017, indicated that behavioural symptoms had triggered as the resident was noted to have exhibited physically abusive behaviour.
The clinical record review revealed that behavioural triggers were not identified for the resident #061 when they exhibited responsive behaviours.
Interview with the BSO RPN #139 confirmed that the behavioural triggers once identified were to be documented in the care plan.
The home's policy called "Responsive Behaviours Program Overview", Index:

SP-B-10, and effective January 2014, directed staff to identify the causes and triggers to prevent responsive behaviours.
The ADOC confirmed that the behavioural triggers were not identified for resident #061.

The home failed to ensure that behavioural triggers for resident #043, #046 and #061were identified to assist in managing the residents' responsive behaviours.

The home failed to ensure that behavioural triggers for resident #043, #046 and #061were identified to assist in managing the residents' responsive behaviours. (561)

2. The licensee failed to ensure that the strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

A) A critical incident report was submitted to the Director on a specific date in May 2017, in relation to resident to resident alleged physical abuse. The critical incident report indicated that resident #061 allegedly pushed resident #060 on a specific date in May 2017, causing them to fall; however this incident was not witnessed by staff or any other residents. Resident #060 sustained an injury and was sent to hospital for further assessment. Both residents were deemed to be cognitively impaired.
The clinical record review indicated that resident #061 was on Dementia Observational System (DOS) monitoring while this incident occurred as a result of the previous responsive behaviour on a specific date in May 2017. The RAI-MDS quarterly assessment dated May 2017, indicated that the resident had physically abusive behavioural symptoms and this behaviour occurred one to three days in the last seven days and this change in behavioural symptoms had deteriorated. The previous RAI-MDS assessment dated March 2017, indicated that the resident had none of these behaviours. The RAP dated May 2017, indicated that behavioural symptoms had triggered as the resident was noted to have exhibited physically abusive behaviour. The RAP also indicated that the resident was at risk for harming others as well as themselves, and care plan goals and interventions were reviewed by the care team to ensure effective interventions were implemented to improve their overall behaviour.
On a specific date in May 2017, the staff initiated an SBAR huddle as a result of the responsive behaviour.
The interviews with PSW #102 and RPN #114 confirmed that the resident had

behaviours. RN #135 was also interviewed and confirmed the resident had been placed on DOS monitoring on a specific date in May 2017, as per the SBAR Huddle recommendation and continued to be on DOS monitoring while this incident occurred.
The written plan of care was reviewed and did not address the responsive behaviours and no strategies were documented in the written plan of care to address these behaviours.
Resident #061 was observed in June 2017 sitting with other residents in the room calling out, no staff attended to the resident. RN #135 stated that this was the resident's usual behaviour.
The ADOC was interviewed and confirmed that the plan of care and strategies were not developed and implemented to respond to resident #061's responsive behaviours. (561)

B) Resident #043 had a history of responsive behaviours related to resisting and refusing care, as well as sexual behaviours, which were exhibited in January and September, 2016. The sexual behaviours exhibited occurred on a specific date in September 2016, whereby resident #043 was observed by the staff exhibiting sexual responsive behaviours towards resident #043.
The clinical record was reviewed and based on the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) in November 2016, the resident's behavioural symptoms had deteriorated since the previous assessment in September 2016.
The written plan of care dated November 2016, identified that the resident had a history of exhibiting behaviours towards a co-resident. There was no date or identification of which co-resident the written plan of care was referring to, and there was no strategies developed or implemented to respond to the resident's sexual behaviours. The LTCH Inspector #527, identified that in May 2014, the home "RESOLVED" the strategies and interventions to reduce the incidents of inappropriate sexual behaviours the resident was exhibiting. The Behavioural SBAR - Huddle Communication Tool was reviewed and it did not include any recommendations or interventions and did not indicate that the resident's plan of care was reviewed and revised.
RPN #126 was interviewed and they were aware of the incident and that the resident that caused the resident's sexual behaviours on a specific date in September 2016, was resident #044. The RPN, who did not witness the incident, indicated that it was resident #044 who initiated the sexual activity with resident #043.
BSO RPN #139 was interviewed along with BSO PSW #144, they were not

aware of what the strategies were developed and implemented to manage the resident's sexual behaviour in September 2016. They indicated that when the interdisciplinary team conducted the Behavioural SBAR Huddle after the incident then they should have updated the written plan of care with new strategies or reviewed the current strategies to address the resident's sexual behaviours.
The DOC and ADOC were interviewed and they were unable to identify what strategies were developed and implemented to respond to resident #043's sexual behaviours.

The home failed to ensure that strategies were developed and implemented to respond to these responsive behaviours for resident #043 and #061.
(561)

3. The licensee failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) Resident #020 triggered for inspection for having unclean fingernails. During the inspection process, the resident was observed on five occasions in May and June 2017, with debris under their fingernails. On a specific date in May 2017, the resident was observed at lunch with two other residents. On a specific date in June 2017, the resident was observed with debris under their fingernails. The resident's hands had an odour.
Interview of PSWs #101, #113 and #148, RPN #131, RN #106 and the Administrator who told the LTCH Inspector #640, that resident #020 frequently refused care.
Interview of the family member who told the LTCH Inspector the resident only preferred a particular PSW to provide care and does not like care by people they were not familiar with.
The plan of care directed staff to provide nail care on bath days and as needed. If the resident refused care, staff were directed to re-approach after five to ten minutes. If the resident still refused care, staff were directed to call the Power of Attorney (POA) and inform them about the situation.
The clinical record revealed there were no assessments and reassessments completed by the home, related to responsive behaviours and no documentation of responses to interventions.
Interview with RN #106, RPN #139 and the Administrator who confirmed the resident had not had any assessments or reassessments completed for the

responsive behaviour of refusal of care and there was no documentation regarding the resident's responses to the interventions. (640)

B) Resident #045 had responsive behaviours, which were manifested in their wandering of the hallways and in and out of other resident rooms. On a specific date in November 2016, resident #045 wandered into resident #046's room. Resident #046 was observed by staff exhibiting sexual responsive behaviours towards resident #045.
The clinical record was reviewed and the written plan of care, dated September 2016, directed the staff to monitor resident #045's location every 30 minutes and document on the wanderer's checklist.
The home's policy called "Wandering Resident Protocol", index NAM-J-10 and effective date January 2014, directed staff that if a resident was at risk for wandering they were to document on the monitoring record and this would be kept on the resident's file once completed.
The resident was observed on four occasions in June 2017, wandering the unit. On two specific dates in June 2017, resident #045 was observed wandering into another resident's room and just as they were entering the room, PSW #134 re-directed the resident.
PSW #146, #147 and RPN #115 were interviewed and indicated that one of the interventions to manage the resident's responsive behaviour of wandering was to allow the resident to wander on the unit, check on the resident every 30 minutes and document on the wanderer's checklist.
The BSO RPN #139 and PSW BSO #127 were interviewed and confirmed that the monitoring every 30 minutes for the resident was in response to their wandering behaviours and the intervention ensured the resident's safety and they were protected.
The DOC and ADOC were also interviewed and confirmed the intervention for monitoring the resident every 30 minutes was to ensure the resident was safe and that they were protected. The DOC and ADOC indicated that the monitoring of resident #045 was expected to be documented on the wanderer's checklist by the staff.
The home failed to ensure that the staff documented resident #045's behaviours on the DOS monitoring sheet. (527)

C) The clinical record was reviewed for resident #061, which indicated that the resident demonstrated behaviours on a specific date in May 2017. The clinical record identified that this was a new change in behaviour. The Behavioural SBAR - Huddle Communication Tool that assessed a new incident of responsive

behaviour indicated that the resident was being placed on DOS monitoring.
The interview with RPN #152, who initiated the SBAR huddle stated that they remember initiating DOS monitoring. The resident's hard copy chart was reviewed and the DOS monitoring could not be found. RPN #135 reviewed the progress notes and the resident's chart and could not find the DOS monitoring checklist and staff did not document in the progress notes whether one was started on a specific date in May 2017.
The ADOC was interviewed and confirmed that the home could not find the DOS charting that was initiated on a specific date in May 2017; however they found one that started on eight days later.
The home failed to ensure that the staff documented resident #061's responsive behaviours on the DOS monitoring sheet. (561)

D) Resident #005's plan of care was reviewed and indicated that they had a history of a specific infection, was at high risk for falls, and had a cognitive impairment.
Review of the clinical record revealed that the resident had responsive behaviours; however these behaviours had increased in the month of March and April 2017. The behaviours. The progress notes for a specific date in February 2017, indicated the resident was exhibiting responsive behaviours. On a specific date in March 2017, the resident continued to have increasing responsive behaviours.
The Electronic Medication Administration Record (EMAR) for the month of March 2017, was reviewed and indicated that medication was ordered by the physician as needed (PRN) and was given to the resident on three specific dates and times in March 2017. The medication was also given a number of times in the month of April 2017.
The progress notes indicated that the resident had responsive behaviours and on two specific dates in April 2017, the resident was discovered by a PSW had fallen.
On a specific date in April 2017, a referral was done to the Behaviour Supports Ontario (BSO).
On another date in April 2017, the resident fell again and injured themselves. Upon arrival at the hospital the resident was assessed for possible infection and the laboratory results confirmed the infection.
Interview with the registered staff #107 indicated that it was the expectation that a physician was called and an order obtained for samples for testing of residents that displayed increased behaviours and were cognitively impaired. Increased behaviours could be a sign or symptom of an infection. Resident #005 had a

history of infection and had exhibited increased responsive behaviours.
Interview with the DOC and ADOC on May 29, 2017, confirmed that resident #005 was unable to express their needs or communicate. They also confirmed that resident #005 had a history of infections and if residents displayed symptoms of restlessness registered staff were expected to get an order for a sample to be tested.
The Administrator was interviewed on a specific date in May 2017, and stated that they would trust that nurses possess nursing judgement and skill to know when to call the physician if residents require to get an order for a sample for testing. Furthermore, if a resident displayed increased behaviours and this was the only indication of a possible infection for a resident who is cognitively impaired or cannot communicate their needs, it would be an expectation that the physician was called for further direction.
The Responsive Behaviours policy, index SP-B-05, effective January 2014, indicated that "responsive behaviours is a term used to describe a means by which persons with dementia or other conditions may communicate their discomfort with something related to for example, the physical body, e.g. urinary tract or other infection, therefore an interdisciplinary assessments are carried out and problem solve for possible solutions an one of them being possible causes of behaviour to be investigated further".
Resident #005 had a history of infections, was cognitively impaired, had increased behaviours, had three falls within a few days, and the third fall which resulted in an injury. The tests completed upon arrival at the hospital indicated that resident had an infection.
The home failed to ensure actions were taken to respond to the needs of resident #005, including assessments and reassessments. (561)

E) A critical incident report was submitted to the Director indicating that resident #007 was physically abusive to resident #051 on a specific date in October 2016.
Resident #007's clinical records were reviewed and indicated that the resident did not have a history of responsive behaviours. The progress notes revealed that on a specific date in October 2016, resident #007 had increased responsive behaviours. Registered staff obtained an order from the physician for as sample for testing in the first week of October 2016.

On a specific date in October 2016, the resident allegedly physically abused resident #051.
On a specific date in October 2016, the progress noted indicated that the staff

tried to collect a sample for testing but it was inadequate.
On a specific date in October 2016, it was documented that the staff were unable to collect a sample for testing as resident refused.
On a specific date in October 2016, the resident had behaviours of wandering.
On a specific date in October 2016, the resident was seen by the physician; however no documentation was found indicating that the doctor was aware of the fact that resident had been refusing the sample for testing and no new orders were obtained.

Interview with RPN #130 indicated that they could not recall if the physician was notified about the resident refusing the sample for testing. If they did, it would have been documented in the communication book.
The ADOC reviewed the communication book with LTCH Inspector #561 and there were no notes provided to the doctor about the resident refusing the sample for testing in the month of October 2016. Furthermore, on a specific date in October 2016, the progress note stated that the staff could not collect the sample again; however later on that day the sample was collected.
On a specific date in October 2016, the laboratory result came back indicating that the sample was contaminated. Two days later in October 2016, the progress note indicated that staff were unable to collect the sample for testing again.
Resident #007 was seen by the physician on a specific date in October 2016; however the physician was not notified of the resident was refusing the test a second time. The following day, the progress notes indicated that the resident was confused and staff were unable to collect the sample. Towards the end of October 2016, staff were able to collect the sample. The results of sample came back positive for infection and a physician's order was obtained for treatment.
Interviewed RN #107, who indicated that if staff were unable to collect the sample several times, the physician should have been called to reassess and possibly an order for procedure should have been obtained for collection of the sample.
The ADOC was interviewed in June 2017, and indicated that the physician should have been called earlier for a treatment order because the resident had symptoms of an infection and the staff were not able to collect the sample.
The home failed to ensure that actions were taken to meet the needs of resident #007, who was demonstrating an increase in responsive behaviours included reassessment of the resident. (561)
(640)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall ensure the following:

1) That a weight monitoring system is in place to measure and record all resident's weights monthly, where clinically indicated, and an assessment by the RD is completed.
2) That the home has the required equipment to measure all residents' weights.
3) That audits are completed to ensure all residents' weights are completed monthly and that residents with a significant weight change are referred to the Registered Dietitian (RD).

Grounds / Motifs :

1. The licensee failed to ensure that the nutrition care and hydration program included a weight monitoring system to measure and record each resident's weight monthly.

2. The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (3), in keeping with s.299(1) of the Regulation. The potential for harm of residents that were high nutritional risk, scope of three residents, and the Licensee's history of noncompliance (VPC) on the August 31, 2016 Resident Quality Inspection with the r. 68 related to the home's nutrition and hydration program.

3. A) Resident #054 was at moderate nutrition risk and had a specific goal weight range. Resident #054's weight declined in May, below the resident's goal weight range. There were no documented weights for March and April 2017.
In an interview with the Registered Dietitian (RD) in May 2017, it was confirmed that resident #054 did not have a recorded weight for March and April 2017.

B) Resident #053 was at high nutrition risk and had a Body Mass Index (BMI), which was defined as "very severely underweight". Resident #053's weight had decreased.
A review of the monthly weights showed the last measured weight for resident #053 prior to the March 2017 was December 2015. In December 2015, resident #053 weighed approximately several kilograms higher.
During an interview with the Administrator in May 2017, it was shared the home purchased a new scale and a weight clinic was initiated in March 2017. It was identified that if residents could not be weighed using the bath chair scale a weight was not taken.
In an interview with the RD in May 2017, it was confirmed that resident #054 had no measured weights between December 2015 and March 2017.

C) Resident #055 was at high nutrition risk and had a BMI, which was defined as "severely underweight". Resident #055's weight was low in April 2017.
A review of the monthly weights showed the last measured weight for resident #055 prior to March 2017 was March 2015. In March 2015, resident #055 weighed approximately eight kilograms higher.
During an interview with the Administrator in May 2017, it was shared the home purchased a new scale and a weight clinic was initiated in March 2017. Prior to this, it was identified that if residents could not be weighed using the bath chair scale a weight was not taken.
In an interview with the RD in May 2017, it was confirmed that resident #055 had no measured weights between March 2015 and March 2017.
(583)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2016_467591_0010, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Order / Ordre :

The licensee shall complete the following:

1) Ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the act, staff apply the physical device in accordance with any manufacturer's instructions, and
2) Ensure that manufacturer's instructions for all physical devices used, to include those devices on loan, to restrain residents under section 31 or section 36 of the Act are readily available for all staff who apply the physical devices.

Grounds / Motifs :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by physical device under section 31 or section 36 of the Act; 1. Staff applied the physical device in accordance with any manufacturer's instructions.

2. The Order is made based upon the application of the factors of severity (2), scope (1) and compliance history (4), in keeping with s.299(1) of the Regulation, in respect of the potential for harm that resident #027 could have experienced, the scope of one isolated incident, and the licensee's history of noncompliance with an Order despite action taken by the Ministry with respect to r. 110 (1)

related to the resident's physical device not being applied according to the manufacturer's instructions.

3. Resident #027 was observed on a specific date in May 2017, in a mobility device in the upright position with a physical device in place. The physical device was fastened but loose. The resident's family member confirmed the resident was unable to release the physical device. The physical device was further observed over a period of several hours on three occasions in May 2017, fastened but loose to the breadth of five fingers between the physical device and the resident.
The resident was assessed as high risk for falls. The resident had four falls in April 2017 as a result of leaning forward in their mobility device.
The home's policy called “Restraint Program”, Index: CPM-E-20, and revised January 2017, directed staff to apply a restraint in accordance with the manufacturer’s instructions.
Interview of PSW #132 and #133, told the LTCH Inspector #640 that the physical device should be tighter to the depth of one flat hand between the physical device and the resident. They also confirmed the resident was unable to release the physical device.
Interview with RPN #131, confirmed the physical device was a restraint and they identified the physical device once tightened, loosened on its own. RPN #131 was unable to locate the manufacturer’s instructions for the physical device.
Interview with RN #106 and PSW #138, confirmed the physical device was applied to prevent the resident from falling.
The Director of Care (DOC) and the Assistant Director of Care (ADOC) were interviewed and confirmed the home did not have the manufacturer’s instructions for the physical device in place for resident #027.
During the RQI, resident #027 had been in a loaner mobility device awaiting the repair of their personal mobility device.
The home did not have the manufacturer’s instructions for the loaner mobility device as confirmed by the DOC and the ADOC during interview with the LTCH Inspector.

The home failed to ensure that staff applied the physical device for resident #027, in accordance with any manufacturer's instructions.
(640)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Order / Ordre :

1. The licensee shall ensure there are guidelines developed and implemented, which will direct staff the steps to be taken to notify the mobility service provider regarding required service for repair and /or provision of loaner equipment.
2. The licensee shall ensure that all direct care and management staff have been trained in the implementation of the guidelines.
3. The licensee shall develop and implement an auditing process to ensure the guidelines have been complied with.

Grounds / Motifs :

1. The licensee failed to ensure that mobility devices, including wheelchairs, walkers and canes were available at all times to residents who require them on a short-term basis.

2. This non-compliance was issued as a compliance order (CO) due to a severity level of actual harm (3), a scope of pattern(2) and a compliance history in the last three years of "one or more unrelated non-compliance"(2) in keeping with s.299(1) of the Regulation.

3. A) Resident #037 was dependent on a personalized device for all mobility. On a specific date in April 2017, the resident's personal mobility device broke. During stage 1 resident interview, resident #037 told the Long Term Care Home (LTCH) Inspector #640 that the resident was upset at having to use another resident's mobility device due to their device being broken for a month. Outside resident #037's room, on a specific date in May 2017, the LTCH Inspector observed the broken mobility device with the repair requisition dated on a specific date in April 2017.
Review of the clinical record revealed that resident #037 had been required to

stay in bed for seven days until the resident received the loaner mobility device from resident #047 on a specific date in May 2017.
During an interview with RN #105, they told the LTCH Inspector that resident #037 had been using the mobility device of resident #047 for three weeks as a result of resident #037's mobility device being broken. The RN also stated that permission was received from resident #047's family to use the mobility device for another resident for a few days.
Interview with resident #047 and their family revealed that both were upset at being asked to loan out the personalized mobility device and also upset as to the length of time the mobility device had been out on loan to another resident.
Review of the contract between the home and mobility service provider, revealed the service provider willing to provide loaner equipment when required.
Review of available equipment with RN #105, the Director of Care (DOC) and the Assistant Director of Care (ADOC), they all told the LTCH Inspector the home did not have an inventory of equipment. They had one wheelchair which had been broken for several months.

B) Resident #041 was dependent on a personalized mobility device for all mobility. On a specific date in May 2017, the resident's personal mobility device broke.
The LTCH Inspector #640 observed the mobility device losing a part as staff were taking the resident into their room. PSW #101 informed the LTCH Inspector that the PSW had completed the appropriate requisition for the service provider and informed the nurse in charge. RN #105 informed the LTCH Inspector the service provider had been notified and were to attend the home that evening and bring a loaner mobility device as the home does not have an inventory of mobility devices for short-term use.
Observation of the resident by the LTCH Inspector at a specific time and date in May 2017, observed the resident to be in bed.
Interview of RPN #126, revealed knowledge of the broken mobility device and the resident would have to eat dinner in the bed. Observation of resident #041 the following day in May 2017, revealed the resident to be in bed, the mobility device not repaired and sitting in the hallway with a note attached to it. Interview with RPN #114 who told the LTCH Inspector the service provider had been in last evening. RPN #114 was not aware of why the mobility device had not been repaired or why there was no loaner as promised. RN #105 told the LTCH Inspector that the service provider had been in last evening but did not repair the mobility device or leave a loaner mobility device.
Review of the requisition for repair by the LTCH Inspector did not show any

documentation to identify the service provider had been in and/or why there were no repairs completed or a loaner mobility device left for this resident. The mobility device was repaired during the last week in May 2017, by the home's service provider. The resident had remained in bed for lunch.
Review of the contract between the home and the service provider, by the LTCH Inspector, revealed the service provider willing to provide loaner equipment when required.
Review of available equipment in the home, with RN #105, the Director of Care (DOC) and the Assistant Director of Care (ADOC), they all told the LTCH Inspector the home did not have an inventory of available equipment for resident use. They had one mobility device which had been broken for several months. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

1) The licensee is to provide training and education to all registered staff related to the implementation of head injury routine and the home's policy as part of the home's post fall assessment policy and procedure.
2) The licensee must ensure compliance with the post fall assessment policy and procedure that includes the Head Injury Routine by developing and implementing an auditing process.
3) The licensee is to ensure that all residents assessed as requiring head injury routine, that the head injury routine is documented as per the home's policy.
4) The licensee is to develop an auditing tool to ensure compliance with the documentation of the required head injury routine.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

2. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (3), in keeping with s.299(1) of the Regulation, in respect of the actual harm / risk experienced by residents, the scope was isolated, and the Licensee's history of noncompliance.

3. In accordance with the Long Term Care Home Act (LTCHA)2007, s.48, which required the licensee to ensure that the interdisciplinary programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments.

A) The Nurse Practitioner (NP) assessed resident #027 on a specific date in May 2017, and the resident was subsequently transferred to the hospital. The NP noted the resident had elimination issues over a period of five days in April 2017.
The home's policy called "Bowel and Bladder Continence Care Program Overview", Index: CPM-B-10, and revised February 2016, directed PSWs to notify registered staff when the resident did not have a bowel movement for more than 48 hours. Registered staff were directed to review their Resident Home Area bowel/bladder records and to follow up daily and obtain and/or initiate appropriate interventions according to the Physician/NP orders. The policy called "Bowel Protocol: Management of Constipation", revised June 2015, directed staff to initiate the protocol when there was no bowel movement outside the normal pattern for the resident.
Review of the clinical record revealed staff did not review and identify that the resident had elimination problems for six days, until the NP assessed the resident, and therefore did not implement the appropriate protocol for the resident.
Interview with RN #106 who confirmed that staff had not reviewed and identified resident #027 had elimination problems for six days. The RN also confirmed the protocol had not been initiated.
Interview with the ADOC confirmed that staff did not identify resident #027 had elimination problems for six days and the protocol was not initiated. The ADOC told the LTCH Inspector that it was the expectation of the home that PSWs notify the registered staff when the resident had elimination problems over 48 hours and registered staff were expected to review the resident's records daily and implement appropriate interventions.
The home failed to ensure that staff complied with their policies, procedures and protocols related to the care of resident #027.

B) On a specific date in December 2016, resident #048 had an unwitnessed fall and sustained an injury.
At the beginning of January 2017, the family member requested the resident to be sent to hospital due to having fallen several times in a short period of time,

which resulted in an injury. Resident #048 remained in hospital and had deteriorated according to the family member.
The home's policy called "Head Injury Routine", Index: NAM-F-65 and revised February 2016, directed staff to initiate head injury routine (HIR) assessment for any unwitnessed fall to identify promptly any neurological changes. HIR was to be initiated immediately and be completed as follows; every 30 minutes for one hour, every hour for two hours, every two hours for four hours, every four hours for 24 hours and once a shift for seven days.
Review of the clinical record identified the HIR assessments to be incomplete. Immediately following the fall, the HIR assessment was initiated but did not include assessment of both pupils. A half hour later, one hour later and at bedtime the day of the fall, and just after midnight the following day, no HIR assessment was completed. There was no assessment of the pupils on nine occasions of a possible 18, eight of which were scheduled to be completed immediately following the unwitnessed fall.
Interview of RPN #152, the nurse initiating the HIR, who concluded the HIR assessments were not completed as per policy. In hindsight, the RPN stated, the HIR policy and assessments should have been followed.
During interview with the ADOC by the LTCH Inspector, the ADOC informed the LTCH Inspector the HIR policy had not been followed and in the absence of a physician's specific order for head injury routine, it was expected that the Head Injury Routine be followed as directed in the policy.
The licensee failed to ensure that the home's Head Injury Routine policy was complied with.

C) On a specific date in May 2017, resident #058 had a witnessed fall and sustained an injury.
The home's policy called "Falls Intervention Risk Management (FIRM) – Implementation", Index CPM-C-20, and revised October 2016, directed staff to complete a Post Fall Assessment in Point Click Care (PCC) and if the fall was unwitnessed or the resident hit their head, the Head Injury Routine (HIR) was to be initiated.
On a specific date in May 2017, the Nurse Practitioner was requested to assess resident #058 due to deterioration. The resident was sent to the hospital for further assessment.
HIR was initiated immediately post-fall and was to be completed as follows; every 30 minutes for one hour, every hour for two hours, every two hours for four hours, every four hours for 24 hours and once a shift for seven days. Review of the clinical record identified the HIR assessments to be incomplete and

documentation confusing. The clinically appropriate assessment instrument had a specific date in May 2017, and made no note of the resident's injury. The progress note in reference to a fall huddle, was dated at the beginning of May 2017, made reference to a fall with injury that occurred at that date. A head injury routine was already in place related to a fall that occurred earlier in April 2017. The vital signs and HIR were not documented for several dates and times in May 2017. A couple of days later in May 2017, there was no HIR assessment completed.
The resident had a subsequent fall on a specific date in May 2017. The HIR assessment tool was initiated as per policy however, the first six HIR assessments were not documented as complete.
During an interview with the ADOC, they indicated that it was the expectation of the home that when there was an unwitnessed fall and/or a head injury, the HIR was to be completed as directed by the policy unless there was a subsequent physician order with directions other than the ones included in the HIR policy. In this case, there were none. During an interview with the Administrator, the Administrator indicated that it was the expectation of the home that the policy for falls prevention, which included directions for the initiation of the Head Injury Routine, were to be followed as written in the policy.

The licensee failed to ensure that the home's policy Head Injury Routine was complied with for resident #048 and #058. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 27, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 22nd day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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Name of Inspector / Nom de l'inspecteur : Kathleen Millar

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