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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 17, 2015;	2015_380593_0020 (A2)	S-348-15, 12823-15	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

GILLIAN CHAMBERLIN (593) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requested a one week extension to the plan submission date for orders #005, #006, #007 and #008. The new submission due date for the compliance plans is September 25, 2015, this is reflected in the order report. The compliance date for the orders remains at October 02, 2015.

Issued on this 17 day of September 2015 (A2)

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

Original report signed by the inspector.

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GILLIAN CHAMBERLIN (593) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 27 - 31, 2015.

Each compliance order that is being served in this report is being referred to the Director. The Director is reviewing the entire report including the home's compliance history.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Services Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Personal Support Workers (PSW), residents and family members.

The inspectors observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Snack Observation

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **0 VPC(s)**
- **9 CO(s)**
- **6 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
LTCHA, 2007 s. 6. (11)	CO #003	2015_269597_0003	616
O.Reg 79/10 s. 73. (1)	CO #009	2015_269597_0003	593
O.Reg 79/10 s. 9. (1)	CO #007	2015_269597_0003	594

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that there was a written plan of care for resident #006 that set out clear directions to staff and others who provide direct care to the resident in regards to the use of a safety device.

The plan of care records were reviewed for resident #006 who was discharged from the home prior to the inspection. The last plan of care review was completed one month prior to discharge which indicated that the resident had been assessed as requiring a safety device. The interventions in the plan of care indicated the use of a safety device which the resident was able to use independently.

Inspector #616 reviewed a MDS kardex report provided by #S-112 on July 29, 2015 which did not identify the safety device. During an interview with the inspector, #S-112

confirmed that the kardex for resident #006 documented the most current information prior to the resident's discharge. #S-112 reported to Inspector #616, that they were unable to provide a point of care (POC) Kardex Report to confirm whether this safety intervention was noted for PSW reference, however they did provide a Task List Report which identified other safety devices used. There was no reference to this specific safety device. [s. 6. (1) (c)]

2. The licensee has failed to ensure there was a written plan of care for resident #003 that sets out clear directions to staff and others who provide direct care to the resident regarding the use of a safety device.

A review of resident #003's progress notes by Inspector #616 found that the resident had an unwitnessed fall. The progress note documented by #S-104 indicated that the POC and careplan were updated to indicate: safety device to be used by resident while in bed.

The Inspector observed the resident in bed during the afternoon of July 30, 2015 with the safety device in use. The inspector reviewed the Plan of Care binder on July 30, 2015 at 1646h for resident #003's care plan and found no update to the paper copy which was the most recent care plan for this resident. There was no reference to the safety device in the care plan, as observed, and as referenced in the progress notes.

During an interview with #S-116, PSW on July 31, 2015, they reported to Inspector #616 that they had knowledge of the resident's recent fall and stated that the resident now has a safety device while in bed. #S-116 demonstrated to the inspector how they would access this information on the POC "visual bedside kardex report" under the section Safety-falls restraints/PASD. However, the safety device was not listed as an intervention as reported by #S-116.

#S-104 with #S-121, clarified and demonstrated to the inspector on July 31, 2015 at 1350h that #S-104 had entered the updated safety device in the resident's electronic care plan and kardex however both staff were now reportedly aware that the information was not transferred to the POC system used by the PSWs. A demonstration undertaken by a PSW for Inspector #616 at two different POC terminals on the unit, identified that the information was missing from the resident's POC Kardex and PSW task list.

#S-104 confirmed to Inspector #616 that they had not updated the paper copy of the resident's care plan filed in the Plan of Care binder with the latest safety intervention

related to resident #003's recent fall. At this time, #S-121 confirmed that the PSW staff did not have clear direction regarding the plan of care for resident #003 related to safety interventions related to using the safety device while in bed as the POC system did not list the current safety intervention for this resident and the paper copy of the care plan had not been updated. [s. 6. (1) (c)]

3. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provide direct care to the resident in regards to staff monitoring the resident's pain.

Resident's plan of care was reviewed by the inspector and it indicated that staff were to observe and monitor for pain and administer medication when needed. Resident #001's plan of care related to pain was reviewed by the inspector and it indicated that staff were to assess the resident for pain during any interactions and observations of the resident using a specific document. The care plan further documented that the resident will voice complaints of pain physically and verbally when experiencing pain, and that a Pain Flow sheet was initiated several months earlier.

During an interview with #S-110, they reported to Inspector #616 that they report pain to the RPN when the resident indicates they are in pain, adding that they were unaware of monitoring the resident's pain on a pain flow sheet and could not locate or provide a continual pain monitoring flow sheet. #S-106 also confirmed to the inspector that RPNs complete the Pain Monitoring Sheets when the pain medications are administered and was unaware of any form titled, "Pain Flow Sheet" and they also confirmed that there was not any resident currently on continuous monitoring.

During an interview with the DOC, they confirmed to Inspector #616 that the monitoring form is the form to be used when a resident is ordered monitoring. During an interview with the ADOC, they reported that the monitoring form is usually only used for monitoring responsive behaviours. The ADOC was unable to identify what the pain flow sheet was and stated that the pain intervention is "wrong".

The written plan of care for resident #001 did not set out clear directions to staff and others who provide direct care related to pain monitoring for the resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provide direct care to the resident, regarding the use of treatment creams.

Inspector #616 reviewed resident #002's electronic Treatment Administration Record (e-TAR) over a five month period related to a treatment cream order to be applied. The administration notes indicated that an additional treatment cream was to be held due to another condition.

During an interview with the ADOC, they confirmed to Inspector #616 that the use of code "10" on the e-TAR represents "RCA/PSW/HCA administered". Throughout a five month period, there were inconsistencies in documentation as to whether Registered staff or PSW applied treatment cream at either of the two regularly scheduled treatment application times. The ADOC also confirmed that the documentation was not clear whether the PSWs have applied either of the treatment creams, one of which was on "hold" and that PSWs apply the treatment cream on hold when needed.

During the review of resident #002's current care plan, Inspector #616 noted that an impaired skin integrity intervention was documented as "apply medicated treatment(s) as per registered staff direction and document on POC". This task was assigned to PSWs. The care plan further instructed PSWs to "apply treatment cream as per TARS". The ADOC confirmed that the PSWs do not have access to the TARs and should not be applying treatment creams, clarified as prescription cream, to residents. [s. 6. (1) (c)]

5. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provide direct care to the resident specifically in regards to the resident receiving medications around meal times.

The inspector reviewed resident #004's plan of care including the Medication Administration Record (MAR) which stated to administer a medication at a specific time prior to the resident getting on the elevator to go for meals, and the RPN was then to call and inform the kitchen that the resident was on their way.

Inspector #594 observed resident #004 receive their medication from #S-122 and then immediately be escorted by #S-122 to the elevator and down to the dining room.

During an interview with Inspector #594, #S-123 stated that staff from the resident's care area will bring the resident to the dining room and let the dietary staff know when they have arrived. The inspector interviewed #S-122 who stated that staff are to administer the medication a specific time before the elevator arrives as per the physician's order, but as the staff never know when the elevator will be arriving they

administer the medication to the resident before taking the resident directly to the dining room and then inform the dietary staff that the resident was in the dining room once they arrived. It was reported by #S-122 that this better met the care needs of the resident. However, as observed by Inspector #594, the care plan had not been updated to reflect this intervention.

Non-compliances have been previously issued under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_269597_0008, including a compliance order served March 13, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (1) (c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was based on an assessment of the resident and the needs and preferences of that resident, in regards to pain management.

Resident #001's Pain Monitoring Sheets over a three month period were reviewed by Inspector #616. The identification of the tool used for the pain assessment was to be selected from a list provided on the form. The tool used by staff was not indicated and/or the score resulting from the tool, was not documented consistently during this period reviewed. Resident #001's pain needs were not being assessed consistently during this time period.

A review of the home's policy Pain Assessment and Symptom Management (LTC-E-80) revised August 2012, identified: The resident's pain will be measured using a standardized, evidence-informed clinical tool. During an interview with Inspector #616, the ADOC reviewed the Pain Monitoring Sheets provided by staff and confirmed that the pain tools were inconsistently completed, and blanks on the monitoring form would indicate that staff used their judgment, not a clinical tool.

Non-compliances have been previously issued under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (2) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

7. The licensee has failed to ensure that the care set out in the plan of care was

provided to resident #013 as specified in the plan in regards to a safety intervention.

During the inspection, Inspector's #593 and #616 observed resident #013, on numerous occasions, engaging in a specific activity in their room.

A hand-written note from a Registered Nursing Staff member was observed posted in resident #013's room. The note indicated a specific safety intervention related to this residents behaviours. In addition, the resident's current care plan also listed the intervention for safety.

On two days during this inspection, Inspector #616 observed that this intervention was not being implemented. During interviews with #S-105 and #S-106, they confirmed that this intervention was in place for the resident's safety. [s. 6. (7)]

8. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan, in regards to the administration of nutritional supplements.

A review of resident #001's physician's orders found a current order for multiple specific nutritional supplements QID (four times daily) at the medication pass.

A review of resident #001's current care plan found that the resident was at high nutritional risk. The interventions to address this in the care plan included multiple specific nutritional supplements to be administered at the medication pass, away from meals.

A review of resident #001's Medication Administration Record (MAR) found that the resident was to receive specific oral nutrition supplements at the medication pass.

On July 28, 2015 at 1504h, Inspector #593 observed an specific oral nutrition supplement on resident #001's bedside. None of this supplement had been consumed by the resident. A review of the MAR found that #S-109 had signed off that this specific oral nutrition supplement had been administered.

On July 30, 2015 at 1028h, Inspector #593 observed a specific oral nutrition supplement on resident #001's bedside. The cup was observed to be full. Inspector #593 continued to observe the resident for the next two hours. At no time during this period, was the resident offered this specific supplement or any other supplement and at 1210h, the supplement was observed to still be sitting at the bedside. A review of

the MAR found that #S-109 had signed off that the specific oral nutrition supplement had been administered at 1042h.

During an interview with Inspector #593 July 31, 2015, at 1010h #S-106 reported that the resident received a variety of oral nutrition supplements. #S-106 also added that if the resident was to refuse the supplement, which is common, staff are to keep the supplement in the refrigerator and try again later. The inspector asked if the resident received a specific oral nutrition supplement, S-106 responded they do not think so. #S-106 checked the MAR to confirm and reported that the resident did not receive this. Inspector #593 reviewed the MAR of resident #001 which indicated that the same specific oral nutrition supplement had been administered at the scheduled time of 1000h.

During an interview with Inspector #593 July 30, 2015, the Registered Dietitian (RD) confirmed that resident #001 was to receive multiple oral nutrition supplements and that when administering the supplements, if the resident refuses, they are to try a few more times to encourage the resident to take them.

A review of the home's policy: LTC-F-20 Medication Administration dated August 2012, found that the medication must be observed for ingestion otherwise it cannot be considered administered and all medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse. [s. 6. (7)]

9. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan in regards to the administration of treatment creams.

Inspector reviewed resident #002's electronic Treatment Administration Record (e-TAR) for a five month period related to treatment cream order to be applied. The administration notes indicated that an additional treatment cream was to be held due to a medical condition.

Inspector #616 completed a review of resident #002's TAR. A period of five months was reviewed by the inspector which found that the cream was missed multiple times during this period and not as administered as stated in the plan of care.

During an interview Inspector #616, the ADOC confirmed that missing documentation for treatment at the scheduled times indicated that the treatment did not occur as

ordered.[s. 6. (7)]

10. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #018 as specified in the plan in regards to a specific responsive behaviour.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018, towards resident #019. It was reported by #S-118 that resident #018 abused resident #019's when they were ambulating past them in a specific resident area.

A review of resident #018's progress notes, found that resident #018 abused resident #019 as they were ambulating past resident #018 in the hallway. Resident #018 was sitting in the hallway after returning from the dining room.

During an interview with Inspector #593 August 5, 2015, the DOC reported that resident #018 cannot ambulate independently. The DOC further reported that the incident of abuse toward resident #019 occurred when resident #018 was brought back to their home area from the dining room after lunch. Whoever was running the elevator, took resident #018 off and left them in a common area of the home. The DOC reported that this is not the protocol, the resident is supposed to be taken down to a different area and provided an activity. The DOC added that there were other residents also coming back from lunch and so there was a crowd in this common area. Resident #019 was navigating past resident #018 when they abused resident #019.

Inspector #593 reviewed resident #018's current care plan dated June 10, 2015, and found the resident had a history of and potential for responsive behaviours as evidenced by responsive behaviours. Interventions in the care plan included one staff to escort to and from areas and staff to ensure resident #018 is not left in main care areas alone with specific residents.

11. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan, in regards to medication administration.

During a record review, Inspector #593 identified three progress notes which documented that resident #002 missed doses of medications because the staff member was not shown how to use the resident care equipment due to a staff

shortage. According to the Nursing Floor Sheet reviewed by Inspector #594 and the DOC, the home was short staffed one RPN on this date. [s. 6. (7)]

Non-compliances have been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015; inspection 2014_269597_0008, including a compliance order served March 13, 2015 and inspection 2014_246196_0006, including a compliance order served May 29, 2014; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (7) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

12. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective in regards to oral hygiene.

The Inspector reviewed resident #001's focused "Oral Hygiene" report for a one month period provided by #S-112, which stated a specific oral hygiene regimen. The response "Resident refused" was documented 15 times and there were four dates where no documentation was entered relating to the provision of oral hygiene.

The inspector reviewed resident #001's current care plan which indicated that the resident required assistance with mouth care as per the oral hygiene schedule. During an Interview with Inspector #616, #S-110 stated that oral care is provided to the resident every AM and after each meal, that evening shift would do the same.

The ADOC reported to Inspector #616, that generally, on the point of care (POC) documentation notes, where it is documented as "resident refused", they would expect staff to try two to three times, sometimes with other staff and if still unsuccessful to document why the care was not provided. The inspector reviewed the POC documentation for the month reviewed for resident #001 and it indicated that the resident refused oral care on 15 occasions. Progress notes for resident #001 were reviewed by the inspector, for corresponding dates of resident refusal of oral care finding no documentation related to the care not being provided. The ADOC confirmed to Inspector #616 that this documentation supported evidence that the resident had not received oral care at least twice per day and that the plan of care had not been revised to identify current interventions relevant to the resident's documented and reported refusals. The resident's oral health interventions were last revised over six months earlier.

Non-compliance has been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015, pursuant to LTCHA, 2007 S.O. 2007, s. 6. (10) Every licensee of a long-term care home shall ensure that the resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when, the residents care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002, 003, 004 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 #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of nursing and personal support services for the home to meet the assessed needs of the residents.

In separate interviews with Inspector #594 it was identified by the Executive Director (ED), Director of Care (DOC) and the Assistant Director of Care (ADOC) that the

staffing plan for the nursing department was as follows:

a) One RN for the building during the day, evening and night shifts

b) One RPN for each of five resident areas during the day and evening shift and one RPN for the building during the night shift

c) Two PSWs for each of four resident areas and three PSWs for one resident area during the day shift, two PSWs for each resident area during the evening shift and one PSW for each resident area during the night shift.

During the course of the inspection, the inspectors observed the following:

Inspector #593 arrived at the home at 0820h July 29, 2015. On the ground floor at the entrance to the elevators there were approximately 10 residents with ambulatory aids including walkers and wheelchairs waiting to use the elevators to return to their home units post breakfast. The button on the elevator was not pressed and so Inspector #593 pressed the button. The left side elevator returned to the ground floor and the doors opened, there was a resident in the doorway of the elevator which prevented access to the elevator. There were no staff members in the area to assist the residents with accessing the elevators. Another resident became upset at having to wait so they walked over to the resident in the elevator, who was in a wheelchair and started to push them off the elevator. The resident in the wheelchair became vocally upset and there were still no staff members in the area. Inspector #593 saw a housekeeping staff member and asked them to intervene. The housekeeping staff member intervened between the two residents, the resident in the wheelchair stayed in the elevator, another resident entered the elevator and the housekeeping staff member then sent the elevator up to the home units. The housekeeping staff member advised Inspector #591 that there should be a staff member in the area to assist the residents and then they left the area. The elevator then returned to the ground floor, the same resident in the wheelchair was still on the elevator blocking the doorway, no other resident could enter the elevator. A PSW then arrived at the elevators and began to assist residents back to their home areas. It was approximately 10 minutes from the time the inspector arrived to the time the PSW arrived to assist residents.

During an interview with Inspector #594 during the inspection, #S-124 stated that a resident had fallen that day. According to the Resident Adverse Event Internal Report, it was documented that the contributing factor leading to the fall was being short staff on the unit. The inspector interviewed the resident who stated that they had a fall

while trying to provide their own care because they had been waiting five minutes for staff to help but they were busy due to the meal service and medication pass. According to the Nursing Floor Sheet reviewed by Inspector #594 and the DOC, the home was short staffed one day shift RPN and two day shift PSWs at the time of the fall.

On July 30, 2015, at 1145h, Inspector #594 observed the resident meal cart with four tray meals on one of the resident areas of the home. Inspector #593 observed that the four tray meals were not provided to residents until 1230h. The trays were not kept in a warmer during this time and staff were not observed to reheat meals before serving. During an interview with Inspector #593 July 30, 2015, #S-110 reported that there were several residents that receive a tray meal in their resident area and also required feeding assistance from staff. They added that they were running a PSW short that day, so there were only two PSWs on the unit. According to the Nursing Floor Sheet reviewed by Inspector #594 and the Scheduler, the home was short staffed one day shift PSW on one specific resident area, thereby pulling the a PSW from another area to fill the vacant staff position on this specific resident area, therefore leaving the other resident area short one PSW.

On July 30, 2015 at 1755h on a resident area of the home, during an interview with Inspector #594, #S-125 reported that they were working on the floor with an RPN but they were unaware of the location of the RPN. The inspector observed the RPN in the medication room. Over a ten minute period, the inspector observed four residents requesting help from #S-125. Resident #021 was yelling for a nurse and requesting a drink, #S-125 was then observed to leave resident #021 to provide assistance to another resident in their room; during this time, the RPN was attending to resident #022 who was requesting their medication. As resident #022 was following the RPN to the nursing station, resident #023 was trying to strike out at resident #022. While the RPN was occupied with resident #022 and #S-125 was occupied with the resident in their room, the inspector observed resident #023 yelling at a resident to get out of their room. According to the Nursing Floor Sheet reviewed by Inspector #594 and the Scheduler, the home was short staffed one evening shift RPN and one evening shift PSW on July 30, 2015.

During an interview with Inspector #594 on July 29, 2015, #S-110 and #S-114 stated that if the home is short staffed, baths don`t get done and because of a staff shortage that day, baths will not be completed. In an interview with the DOC, it was reported to Inspector #593 that if they are short staffed, they try to work smarter and not harder to try to get everything done. If they get to a point where they have to defer care they

would look at each unit, for example tub baths take longer so they may do a sponge bath instead but this depends on who the resident is. The staff usually call the DOC in these situations and they walk through the care needed with the staff and prioritize. The DOC also added that the managers will also pitch in to help with care. When the DOC and ADOC work on the unit, this does not get captured on the staff schedule, so it may look like they are running short staffed. The inspector reviewed the Daily Missed Baths from July 01 to 27, 2015 where on July 04, in the evening, it was documented that no baths were completed on four resident areas because of staff shortage. On July 14, 2015, it was documented that no baths were completed in the evening on three resident areas because of staff shortage.

During a record review, Inspector #593 identified three progress notes which documented that resident #002 missed doses of medications because the staff member was not shown how to use the resident care equipment due to a staff shortage. Inspector #594 reviewed the Medication Administration Record for the resident to see progress notes for resident #002's medication administration times. According to the Nursing Floor Sheet reviewed by Inspector #594 and the DOC, the home was short staffed one RPN on this day.

Given that during the course of the inspection there was a documented pattern of registered nursing or direct care staff that were unable to be replaced on the staffing schedule, there were several incidents when resident care was affected by limited staffing and that through observation by the inspectors, resident care was not being provided, the licensee has failed to ensure that there is an organized program of nursing and personal support services for the home to meet the assessed needs of the residents.

Non-compliances have been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006, including a compliance order served May 29, 2014; pursuant to LTCHA, 2007 S.O. 2007, s. 8. (1) Every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the resident and an organized program of personal support services for the home to meet the assessed needs of the resident. [s. 8. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of dietary services that met the daily hydration needs of the residents.

On July 29, 2015 at 1017h, Inspector #593 observed the covered AM nourishment cart on a specific resident unit. Several residents were observed to be leaving the unit to attend the 1030h church service held in the dining room. These residents had not received a beverage from the AM cart prior to leaving the unit. At 1027h, a resident asked the inspector if they could have a juice or a coffee, at this time the nourishment cart was still covered and there were no staff members in the immediate area. The resident was observed to then leave the area as there were no staff to provide them a beverage. At 1046h, the inspector observed a PSW uncover the nourishment cart and begin to offer the remaining residents a beverage.

On July 29, 2015 at 1015h, Inspector #593 observed the covered AM nourishment cart on on a specific resident unit. At 1025h, the cart was still observed to be covered

and several residents were observed to leave the unit to attend the church service without being offered a beverage. At 1100h, the nourishment cart was still covered on this resident unit, no resident was observed to receive a beverage from the AM nourishment cart prior to the lunch service.

On July 29, 2015 at 1033h, Inspector #593 observed the church service commencing in the dining room on the ground floor. There were 13 residents observed to be in attendance and none of these residents were observed to be offered a beverage during or after the church service which ended just after 1100h.

On July 30, 2015 at 1043h Inspector #593 observed the covered AM nourishment cart on a specific resident unit. No resident had yet received a beverage as part of the AM nourishment pass and until the lunch service began.

During an interview with Inspector #593 July 31, 2015, #S-105 reported that the dietary staff usually bring the nourishment cart to the unit between 1000h and 1030h. #S-105 added, that the home's expectation is that PSWs provide residents a beverage immediately however they are usually busy and are often running short staffed so they are unable to do this.

A review of the home's document- Resident Meal and Snack Times found that the AM nourishment is scheduled for 1000h.

During an interview with inspector #593 August 5, 2015, the Food Service Manager (FSM) reported that the nourishment carts should be delivered to each unit by approximately 1000h. They need to make sure that the carts are delivered by this time especially if there is an activity scheduled for 1030h. The expectation is that the PSWs on each unit are to begin the nourishment pass as soon as they are able to. When the FSM was advised of the delays and lack of provision of the AM nourishment pass, they added that this should not be happening and they have had problems with this previously.

Non-compliances have been previously issued under inspection 2014_380593_0001, including a compliance order served August 7, 2014; inspection 2014_139163_0004, including a compliance order served March 27, 2014; and inspection 2013_139163_0019, including a compliance order served July 30, 2013; pursuant to LTCHA, 2007 S.O. 2007, s.11. (1) Every licensee of a long-term care home shall ensure that there is an organized program of nutrition care an dietary services for the home to meet the daily nutrition needs of the residents; and an organized program of

hydration for the home to meet the hydration needs of residents. [s. 11. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

DR # 003 – 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 LTCHA, 2007, 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. A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018 towards resident #019.

During an inspection completed March 2015 under inspection 2015_269597_0003, a compliance order was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.19. the licensee failed to ensure that residents are protected from abuse by anyone. It was found that on three separate occasions, resident #018 was observed to abuse the same resident in the home. This follow up inspection was completed as a result.

A review of resident #018's progress notes, found that resident #018 abused resident #019 as they were ambulating past them in the hallway. Resident #018 was sitting in the hallway after returning to the resident area, contrary to their plan of care.

A review of the home's investigation into the incident found that #S-118 who witnessed the incident was interviewed and reported the following:

I was standing in the tubroom entrance way and I could see resident #018 in the

hallway behind the fan. I did not see them get off the elevator, so I cannot comment
how long they were there for. There were no staff members near resident #018 at this
time. Resident #019 came by and I saw resident #018 abuse resident #019. I addressed the situation
with resident #018. The PSW intervened and removed resident #018 from the area.

During an interview with Inspector #593 August 5, 2015, the DOC reported that resident #018 cannot ambulate independently. As a result, they require staff assistance to mobilize around the home. The DOC further reported that the incident of abuse toward resident #019 occurred when resident #018 was brought back to the resident area by staff from the dining room after lunch. Resident #018 was left by staff in a common area of the home. The DOC reported that this is not the protocol, they are to be taken down to another area and given an activity. The DOC added that there were other residents also coming back from lunch and so there was a crowd in this resident area. Resident #019 was navigating past resident #018 when they abused them.

Inspector #593 reviewed resident #018's current care plan, and found the resident had a history of and potential for responsive behaviours as evidenced by incidence of abuse of co-residents and staff. Interventions in the care plan included one staff to escort to and from areas and staff to ensure resident #018 is not left in main care areas alone with residents.

A review of the resident's health care record found DOS documentation, implemented for 10 days, incomplete documentation on two of these days and the form was not completed for three of these days consecutively. A review of the resident's chart found "Q15 Minute Check" forms, implemented for four days and incomplete documentation on all four days.

A review of the resident's record found a history of specific responsive behaviours

documented since 2012.

It was found that the incident of abuse towards a resident in the home was not reported immediately to the Director as per the 2007 LTCHA which states that abuse of a resident by anyone that resulted in harm or a risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

As evidenced by documented progress notes and staff interviews, resident #018 was known to exhibit responsive behaviours towards residents in the home. Furthermore, after a compliance order was served as a result of four incidents of abuse, an additional incident of abuse was allowed to occur toward a resident in the home. The licensee has failed to protect resident #019 within the home from resident #018 with known and documented abuse. [s. 19. (1)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 007

DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018 towards resident #019.

The CI was submitted however, the incident actually occurred two days earlier than when the CI was reported to the Director of the MOHLTC.

A review of the home's investigation records found that the incident was reported directly to the unit's RPN #S-120 and the charge RN #S-119 after the incident occurred. The RN completed an internal incident report that same shift however it was not clear when this incident was further reported to the Executive Director (ED)of the home.

A review of the home's policy: LP-C-20-ON Resident Non-Abuse dated September 2014, found that any staff member who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the ED of the home, or if unavailable, to the most senior supervisor on shift at that time. The person reporting

the suspected abuse or neglect must follow the home's reporting requirements to ensure that the information is provided to the ED immediately. Furthermore, the same policy documents that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the MOHLTC- 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.

A review of the home's education records found that education was completed on the home's policy: LP-C-20-ON Resident Non-Abuse dated September 2014, for all staff during June and July 2015.

During an interview with Inspector #593 August 5, 2015, the DOC stated that the incident was reported to the RN in charge shortly after it occurred. The home's process is that the incident is then reported to the manager on call however sometimes there is a delay in this. The manager on call is to complete the CIS. The DOC further added that they run a report daily to view any incidents that have happened the previous day, however this incident occurred on a Saturday therefore the report would not have been generated until the following Monday. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the information upon which it was based to the Director.

In a complaint received by the Director it was stated that resident #006 was witnessed in an altercation with resident #007, and that resident #006 was observed to exhibit responsive behaviours frequently.

Inspector #594 reviewed resident #007's health care record and identified in a progress note, an entry stating that the resident sustained an injury after a resident exhibited responsive behaviours toward resident #007. An internal incident report was completed.

The inspector reviewed the Resident Incident Internal Report , which stated that a resident exhibiting responsive behaviours toward resident #007 which resulted in an injury.

Upon review of resident #006's health care record, the inspector identified a progress note, which documented that resident #006 displayed responsive behaviours toward

resident #007 which resulted in an injury, and specific interventions were listed in this progress note related to these behaviours.

The inspector reviewed CI reports submitted to the Director for resident abuse however this incident had not been reported as required.

The DOC reported to Inspector #594, that when Registered staff are notified about resident to resident abuse, the Registered staff are to document in progress notes and a Resident Incident Internal Report is to be completed. This completed form is then to be sent to the DOC/ADOC. If after hours, the Manager on Call is to be notified and they are to determine if the Director is to be notified, then complete the CI report if required.

During an interview with the Inspector #594, the ADOC reported that no CI report was submitted because the resident was not injured. The inspector reviewed the Resident Incident Internal Report with the ADOC who stated because the report was not completed thoroughly and because the ADOC wasn't there to witness the situation, they were not aware of all the facts including that resident #007 was injured. [s. 24. (1) 2.]

3. The licensee has failed to immediately report to the Director where there were reasonable grounds to suspect abuse of a resident. During an interview with Inspector #594, it was reported by #S-126 that resident #006 injured another resident.

The inspector reviewed the Resident Incident Internal Report Forms from 2013 to 2015. Included with these forms was a hand written description from a direct care staff member who stated that a student witnessed resident #020 displayed responsive behaviours toward resident #006 that resulted in resident #006 sustaining an injury.

The inspector reviewed reports submitted to the Director and failed to identify that the Director was notified.

In a statement received by the inspector, the DOC reported that the suggested altercation was listed in resident #006's chart as 'unwitnessed' and that there was no incident report located nor CI report submitted to the Director. The DOC further reported that staff responded (but were not present) and was indicated in the notation, that there was no injury description or bleeding, though the resident was given a bandaid, no hospitalization required.

The licensee failed to report immediately to the Director. This report to the Director was not contingent upon the licensee completing its investigation or validating the allegation.

A documented pattern of inaction regarding reporting certain matters, specifically resident abuse, to the Director on the part of the licensee was identified by inspectors during this inspection, July 27-31, 2015.

Non-compliance has been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015, pursuant to LTCHA, 2007 S.O. 2007, s. 24. (1) A person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director 2. Abuse of a resident by anyone or neglect of the resident by the licensee or staff that resulted in harm or risk of harm to the resident. [s. 24. (1) 2.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 008

DR # 005 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

During a tour of the home July 28, 2015, Inspector #594 observed a prescribed medication at the bedside of resident #024. The inspector reviewed the Physician's Order for the resident which failed to identify that the medication was to be kept at the bedside.

Inspector #594 interviewed #S-120 who reported that the home's expectation is that no medications are to be at the resident bedside and that no resident in this home area have orders for medication at the bedside. The inspector showed #S-120 the medication at the resident's bedside and #S-120 stated that the resident recently returned from hospital and that the prescribed medication came from the hospital.

During an interview with the DOC, it was reported to the inspector that the home will try and discourage medications at the bedside and documentation such as a physician's order, must be in place if medication is kept with the resident.

Non-compliances have been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006, including a compliance order served May 29, 2014; pursuant to O.Reg 79/10, r. 129 (1) Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart, that is exclusively used for drugs and drug-related supplies and that is secured and locked. [s. 129. (1) (a)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 006 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that respected the resident's dignity.

During the inspection, on day A, Inspector #593 observed resident #015 seated on the toilet, in a washroom located in the corridor on a resident unit of the home with the door open. The resident was visible to those passing through the corridor. The inspector observed several staff members walk past, however none of them shut the door to provide privacy for the resident.

During the inspection, on day B, Inspector #593 observed resident #015 seated on the toilet, in a washroom located in the corridor on a resident unit of the home with the door open. The resident was visible to those passing through the corridor. The inspector observed several staff members walk past, however none of them shut the door to provide privacy for the resident.

A review of resident #015's current care plan, found that resident #015 required extensive assistance with toileting, maintain privacy but stay in immediate area.

During an interview with inspector #593 July 31, 2015, #S-105 reported that when they are toileting a resident, they always ensure that the door is closed and that the resident has access to the call bell. #S-105 added that even though most residents have their own private washroom, the staff usually take them to the washroom in the corridor as it is bigger and more accessible for wheelchairs. In this situation, the door should be shut and the staff would check on the resident every few minutes. They added that there would be no need to have the door opened for any resident. [s. 3. (1) 1.]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018 towards resident #019. It was reported by #S-118 that resident #018 abused resident #019, when they were ambulating past them in a resident area of the home.

A review of the home's investigation records found that the incident was reported directly to the unit's RPN #S-120 and the charge RN #S-119 after the incident occurred. The RN completed an internal incident report that same shift however it was not clear when this incident was further reported to the Executive Director (ED) of the home. #S-119 did not immediately report the witnessed abuse and the information upon which it is based to the Director.

A review of the home's policy: LP-C-20-ON Resident Non-Abuse dated September 2014, found that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the MOHLTC- 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. [s. 20. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan was evaluated and updated annually in accordance with prevailing practices.

A Compliance Order was issued on May 22, 2015 which stated the licensee shall ensure that there is an organized program of nursing and personal support services for the home to meet the assessed needs of the residents, the compliance date for this order was June 19, 2015. Inspector #594 requested the staffing plan evaluation from the Executive Director (ED). The ED reported that the home has not completed an evaluation of the staffing plan. [s. 31. (3) (e)]

Issued on this 17 day of September 2015 (A2)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : GILLIAN CHAMBERLIN (593) - (A2)

Inspection No. / No de l'inspection : 2015_380593_0020 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : S-348-15, 12823-15 (A2)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Sep 17, 2015;(A2)

Licensee / Titulaire de permis :
REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR,
MISSISSAUGA, ON, L5R-4B2

LTC Home / Foyer de SLD :
LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY,
ON, P7E-1J2

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jonathon Riabov

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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_269597_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

The licensee is hereby ordered to complete a thorough review of each resident's plan of care, ensuring that the documented care is reviewed, updated and sets out clear direction to staff and others who provide direct care to the resident.

Furthermore, the licensee is to ensure that PSW's assigned to each resident unit are aware of every plan of care for each resident and that the oversight of this process is managed by the registered nursing staff. The leadership team of the home shall ensure that there is a process for PSW's to follow if the plan of care is not correct or could better reflect resident care needs, ensuring that the plan of care is current and communicated to all PSW's and that the documented care for each resident, meets their current assessed needs ensuring quality of care and quality of life.

This review and update of each resident's plan of care must be completed by October 16, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for resident #004 that set out clear directions to staff and others who provide direct care to the resident specifically in regards to the resident receiving medications around meal times.

The inspector reviewed resident #004’s plan of care including the Medication Administration Record (MAR) which stated to administer a medication at a specific time prior to the resident getting on the elevator to go for meals, and the RPN was then to call and inform the kitchen that the resident was on their way.

Inspector #594 observed resident #004 receive their medication from #S-122 and then immediately be escorted by #S-122 to the elevator and down to the dining room.

During an interview with Inspector #594, #S-123 stated that staff from the resident’s care area will bring the resident to the dining room and let the dietary staff know when they have arrived. The inspector interviewed #S-122 who stated that staff are to administer the medication a specific time before the elevator arrives as per the physician's order, but as the staff never know when the elevator will be arriving they administer the medication to the resident before taking the resident directly to the dining room and then inform the dietary staff that the resident was in the dining room once they arrived. It was reported by #S-122 that this better met the care needs of the resident. However, as observed by Inspector #594, the care plan had not been updated to reflect this intervention. (593)

2. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provide direct care to the resident, regarding the use of treatment creams.

Inspector #616 reviewed resident #002's electronic Treatment Administration Record (e-TAR) over a five month period related to a treatment cream order to be applied. The administration notes indicated that an additional treatment cream was to be held due to another condition.

During an interview with the ADOC, they confirmed to Inspector #616 that the use of code "10" on the e-TAR represents "RCA/PSW/HCA administered". Throughout a five month period, there were inconsistencies in documentation as to whether Registered staff or PSW applied treatment cream at either of the two regularly scheduled treatment application times. The ADOC also confirmed that the documentation was not clear whether the PSWs have applied either of the treatment creams, one of which was on "hold" and that PSWs apply the treatment cream on hold when needed.

During the review of resident #002's current care plan, Inspector #616 noted that an impaired skin integrity intervention was documented as "apply medicated treatment (s) as per registered staff direction and document on POC". This task was assigned to PSWs. The care plan further instructed PSWs to "apply treatment cream as per TARS". The ADOC confirmed that the PSWs do not have access to the TARs and should not be applying treatment creams, clarified as prescription cream, to residents. [s. 6. (1) (c)] (616)

3. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provide direct care to the resident in regards to staff monitoring the resident's pain.

Resident's plan of care was reviewed by the inspector and it indicated that staff were to observe and monitor for pain and administer medication when needed. Resident #001's plan of care related to pain was reviewed by the inspector and it indicated that staff were to assess the resident for pain during any interactions and observations of the resident using a specific document. The care plan further documented that the resident will voice complaints of pain physically and verbally when experiencing pain, and that a Pain Flow sheet was initiated several months earlier.

During an interview with #S-110, they reported to Inspector #616 that they report pain to the RPN when the resident indicates they are in pain, adding that they were unaware of monitoring the resident's pain on a pain flow sheet and could not locate or provide a continual pain monitoring flow sheet. #S-106 also confirmed to the inspector that RPNs complete the Pain Monitoring Sheets when the pain medications are administered and was unaware of any form titled, "Pain Flow Sheet" and they also confirmed that there was not any resident currently on continuous monitoring.

During an interview with the DOC, they confirmed to Inspector #616 that the monitoring form is the form to be used when a resident is ordered monitoring. During an interview with the ADOC, they reported that the monitoring form is usually only used for monitoring responsive behaviours. The ADOC was unable to identify what the pain flow sheet was and stated that the pain intervention is "wrong".

The written plan of care for resident #001 did not set out clear directions to staff and others who provide direct care related to pain monitoring for the resident. [s. 6. (1) (c)]
(616)

4. The licensee has failed to ensure there was a written plan of care for resident #003 that sets out clear directions to staff and others who provide direct care to the resident regarding the use of a safety device.

A review of resident #003's progress notes by Inspector #616 found that the resident had an unwitnessed fall. The progress note documented by #S-104 indicated that the POC and careplan were updated to indicate: safety device to be used by resident while in bed.

The Inspector observed the resident in bed during the afternoon of July 30, 2015 with the safety device in use. The inspector reviewed the Plan of Care binder on July 30, 2015 at 1646h for resident #003's care plan and found no update to the paper copy which was the most recent care plan for this resident. There was no reference to the safety device in the care plan, as observed, and as referenced in the progress notes.

During an interview with #S-116, PSW on July 31, 2015, they reported to Inspector #616 that they had knowledge of the resident's recent fall and stated that the resident now has a safety device while in bed. #S-116 demonstrated to the inspector how they would access this information on the POC "visual bedside kardex report" under the section Safety-falls restraints/PASD. However, the safety device was not listed as an intervention as reported by #S-116.

#S-104 with #S-121, clarified and demonstrated to the inspector on July 31, 2015 at 1350h that #S-104 had entered the updated safety device in the resident's electronic care plan and kardex however both staff were now reportedly aware that the information was not transferred to the POC system used by the PSWs. A demonstration undertaken by a PSW for Inspector #616 at two different POC terminals on the unit, identified that the information was missing from the resident's POC Kardex and PSW task list.

#S-104 confirmed to Inspector #616 that they had not updated the paper copy of the resident's care plan filed in the Plan of Care binder with the latest safety intervention related to resident #003's recent fall. At this time, #S-121 confirmed that the PSW staff did not have clear direction regarding the plan of care for resident #003 related to safety interventions related to using the safety device while in bed as the POC system did not list the current safety intervention for this resident and the paper copy of the care plan had not been updated. [s. 6. (1) (c)]
(616)

5. The licensee has failed to ensure that there was a written plan of care for resident #006 that set out clear directions to staff and others who provide direct care to the resident in regards to the use of a safety device.

The plan of care records were reviewed for resident #006 who was discharged from the home prior to the inspection. The last plan of care review was completed one month prior to discharge which indicated that the resident had been assessed as requiring a safety device. The interventions in the plan of care indicated the use of a safety device which the resident was able to use independently.

Inspector #616 reviewed a MDS kardex report provided by #S-112 on July 29, 2015 which did not identify the safety device. During an interview with the inspector, #S-112 confirmed that the kardex for resident #006 documented the most current information prior to the resident's discharge. #S-112 reported to Inspector #616, that they were unable to provide a point of care (POC) Kardex Report to confirm whether this safety intervention was noted for PSW reference, however they did provide a Task List Report which identified other safety devices used. There was no reference to this specific safety device. [s. 6. (1) (c)]

Non-compliances have been previously issued under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_269597_0008, including a compliance order served March 13, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (1) (c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

The decision to re-issue this compliance order was based on the scope which affected five residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including two compliance orders, NC has continued for 24 months with this area of the legislation. (616)

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

Oct 16, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_269597_0003, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee is hereby ordered to complete a thorough review of each resident's plan of care. The Registered Nursing Staff are to ensure that the documented care set out is based on an assessment of the resident, specifically related to resident needs re: pain management.

Furthermore, the licensee is to develop and implement a written process for the Registered Nursing Staff to ensure that the current plan of care for each resident is clearly communicated to all PSWs and that PSWs have immediate and convenient access to the documented care needs of all residents.

This review and update based on assessments must be completed by October 16, 2015.

Grounds / Motifs :

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

resident #001 was based on an assessment of the resident and the needs and preferences of that resident, in regards to pain management.

Resident #001's Pain Monitoring Sheets over a three month period were reviewed by Inspector #616. The identification of the tool used for the pain assessment was to be selected from a list provided on the form. The tool used by staff was not indicated and/or the score resulting from the tool, was not documented consistently during this period reviewed. Resident #001's pain needs were not being assessed consistently during this time period.

A review of the home's policy Pain Assessment and Symptom Management (LTC-E-80) revised August 2012, identified: The resident's pain will be measured using a standardized, evidence-informed clinical tool. During an interview with Inspector #616, the ADOC reviewed the Pain Monitoring Sheets provided by staff and confirmed that the pain tools were inconsistently completed, and blanks on the monitoring form would indicate that staff used their judgment, not a clinical tool.

Non-compliances have been previously issued under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (2) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

Non-compliances have been previously issued under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (2) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

The decision to re-issue this compliance order was based on the severity which indicates a potential for actual harm and although the scope was isolated, there is a compliance history including one compliance order previously issued in this area of the legislation. (616)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Oct 16, 2015

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2015_269597_0003, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 is required to prepare, submit and implement a plan for achieving compliance under s.6 (7) of the LTCHA. This plan is to include:

1. A training and education program for all staff in the home, including but not limited to registered nursing staff, PSWs, dietary aides and housekeeping staff. The training and education program must include:

* Resident focused care and provision of care according to the current plan of care
* How to deliver resident centred care and prioritize resident centred care when facing staffing challenges
* A focus on the promotion and respect of Resident's Rights specifically the right to be treated with dignity and respect at all times
* Communication among disciplines and between shifts including effective communication strategies to ensure that significant information is communicated immediately as required
* Reporting of significant events/incidents to management/department heads in a timely manner

2. The details related to who will provide this education to staff to ensure that educators possess the necessary expertise.

3. A training schedule including dates of the training/education, how the licensee will ensure the inclusion of all staff including staffing plans, which will ensure that resident care is not affected during the scheduled training.

4. An auditing process undertaken by the leadership team that will identify if this learning has integrated into day to day practice and a plan for corrective action will be developed should the learning not be effective.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by September 25, 2015 and fully implemented by October 30, 2015.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan, in regards to medication administration.

During a record review, Inspector #593 identified three progress notes which documented that resident #002 missed doses of medications because the staff member was not shown how to use the resident care equipment due to a staff shortage. According to the Nursing Floor Sheet reviewed by Inspector #594 and the DOC, the home was short staffed one RPN on this date. [s. 6. (7)] (593)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #018 as specified in the plan in regards to a specific responsive behaviour.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018, towards resident #019. It was reported by #S-118 that resident #018 abused resident #019's when they were ambulating past them in a specific resident area.

A review of resident #018's progress notes, found that resident #018 abused resident #019 as they were ambulating past resident #018 in the hallway. Resident #018 was sitting in the hallway after returning from the dining room.

During an interview with Inspector #593 August 5, 2015, the DOC reported that resident #018 cannot ambulate independently. The DOC further reported that the incident of abuse toward resident #019 occurred when resident #018 was brought back to their home area from the dining room after lunch. Whoever was running the elevator, took resident #018 off and left them in a common area of the home. The DOC reported that this is not the protocol, the resident is supposed to be taken down to a different area and provided an activity. The DOC added that there were other residents also coming back from lunch and so there was a crowd in this common area. Resident #019 was navigating past resident #018 when they abused resident #019.

Inspector #593 reviewed resident #018's current care plan dated June 10, 2015, and found the resident had a history of and potential for responsive behaviours as evidenced by responsive behaviours. Interventions in the care plan included one staff to escort to and from areas and staff to ensure resident #018 is not left in main care areas alone with specific residents.
(593)

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan in regards to the administration of treatment creams.

Inspector reviewed resident #002's electronic Treatment Administration Record (e-TAR) for a five month period related to treatment cream order to be applied. The administration notes indicated that an additional treatment cream was to be held due to a medical condition.

Inspector #616 completed a review of resident #002's TAR. A period of five months was reviewed by the inspector which found that the cream was missed multiple times during this period and not as administered as stated in the plan of care.

During an interview Inspector #616, the ADOC confirmed that missing documentation for treatment at the scheduled times indicated that the treatment did not occur as ordered.[s. 6. (7)] (616)

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan, in regards to the administration of nutritional supplements.

A review of resident #001's physician's orders found a current order for multiple specific nutritional supplements QID (four times daily) at the medication pass.

A review of resident #001's current care plan found that the resident was at high nutritional risk. The interventions to address this in the care plan included multiple specific nutritional supplements to be administered at the medication pass, away from meals.

A review of resident #001's Medication Administration Record (MAR) found that the resident was to receive specific oral nutrition supplements at the medication pass.

On July 28, 2015 at 1504h, Inspector #593 observed an specific oral nutrition supplement on resident #001's bedside. None of this supplement had been consumed by the resident. A review of the MAR found that #S-109 had signed off

that this specific oral nutrition supplement had been administered.

On July 30, 2015 at 1028h, Inspector #593 observed a specific oral nutrition supplement on resident #001's bedside. The cup was observed to be full. Inspector #593 continued to observe the resident for the next two hours. At no time during this period, was the resident offered this specific supplement or any other supplement and at 1210h, the supplement was observed to still be sitting at the bedside. A review of the MAR found that #S-109 had signed off that the specific oral nutrition supplement had been administered at 1042h.

During an interview with Inspector #593 July 31, 2015, at 1010h #S-106 reported that the resident received a variety of oral nutrition supplements. #S-106 also added that if the resident was to refuse the supplement, which is common, staff are to keep the supplement in the refrigerator and try again later. The inspector asked if the resident received a specific oral nutrition supplement, S-106 responded they do not think so. #S-106 checked the MAR to confirm and reported that the resident did not receive this. Inspector #593 reviewed the MAR of resident #001 which indicated that the same specific oral nutrition supplement had been administered at the scheduled time of 1000h.

During an interview with Inspector #593 July 30, 2015, the Registered Dietitian (RD) confirmed that resident #001 was to receive multiple oral nutrition supplements and that when administering the supplements, if the resident refuses, they are to try a few more times to encourage the resident to take them.

A review of the home's policy: LTC-F-20 Medication Administration dated August 2012, found that the medication must be observed for ingestion otherwise it cannot be considered administered and all medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse. [s. 6. (7)] (593)

5. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #013 as specified in the plan in regards to a safety intervention.

During the inspection, Inspector's #593 and #616 observed resident #013, on numerous occasions, engaging in a specific activity in their room.

A hand-written note from a Registered Nursing Staff member was observed posted in resident #013's room. The note indicated a specific safety intervention related to this residents behaviours. In addition, the resident's current care plan also listed the intervention for safety.

On two days during this inspection, Inspector #616 observed that this intervention was not being implemented. During interviews with #S-105 and #S-106, they confirmed that this intervention was in place for the resident's safety. [s. 6. (7)]

Non-compliances have been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015; inspection 2014_269597_0008, including a compliance order served March 13, 2015 and inspection 2014_246196_0006, including a compliance order served May 29, 2014; pursuant to LTCHA, 2007 S.O. 2007, s. 6. (7) Every licensee of a long-term care home shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The decision to re-issue this compliance order was based on the scope which affected four residents, the severity which indicates a potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including three compliance orders, NC has continued for 15 months with this area of the legislation. (616)

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

Oct 30, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2015_269597_0003, CO #011;

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee is hereby ordered to ensure that each resident has been reassessed and the plan of care, including the Point of Care (POC) is reviewed and revised at anytime when the care set out in the plan has not been effective.

This review must be completed by October 16, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective in regards to oral hygiene.

The Inspector reviewed resident #001's focused "Oral Hygiene" report for a one month period provided by #S-112, which stated a specific oral hygiene regimen. The

response "Resident refused" was documented 15 times and there were four dates where no documentation was entered relating to the provision of oral hygiene.

The inspector reviewed resident #001's current care plan which indicated that the resident required assistance with mouth care as per the oral hygiene schedule. During an Interview with Inspector #616, #S-110 stated that oral care is provided to the resident every AM and after each meal, that evening shift would do the same.

The ADOC reported to Inspector #616, that generally, on the point of care (POC) documentation notes, where it is documented as "resident refused", they would expect staff to try two to three times, sometimes with other staff and if still unsuccessful to document why the care was not provided. The inspector reviewed the POC documentation for the month reviewed for resident #001 and it indicated that the resident refused oral care on 15 occasions. Progress notes for resident #001 were reviewed by the inspector, for corresponding dates of resident refusal of oral care finding no documentation related to the care not being provided. The ADOC confirmed to Inspector #616 that this documentation supported evidence that the resident had not received oral care at least twice per day and that the plan of care had not been revised to identify current interventions relevant to the resident's documented and reported refusals. The resident's oral health interventions were last revised over six months earlier.

Non-compliance has been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015, pursuant to LTCHA, 2007 S.O. 2007, s. 6. (10) Every licensee of a long-term care home shall ensure that the resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when, the residents care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (c)]

The decision to re-issue this compliance order was based on the severity which indicates a potential for actual harm and although the scope was isolated, there is a compliance history including one compliance order previously issued in this area of the legislation. (616)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Oct 16, 2015

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2015_269597_0003, CO #010;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,

(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

(A1)
The licensee is required to prepare, submit and implement a plan for achieving compliance under s.8 (1) of the LTCHA:

(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

(b) an organized program of personal support services for the home to meet the needs of the residents.

The plan must include, but is not limited to:

* A staffing contingency plan to address when nursing staff members are unavailable to work
* The use of agency nursing staff as required to ensure the home is fully staffed at all times
* Strategies to be implemented which will ensure that resident care will not be affected should the home operate outside of the regular nursing staff deployment
* Communication plan for nursing staff who provide care which will ensure that care is provided based on resident need
* System to assist nursing staff in prioritizing and re-prioritizing care related to operational pressures of the day.
* The Leadership team must oversee this process and provide strategies should the home operate outside of the regular nursing staffing deployment, including the roles of the leadership team.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by September 25, 2015 and fully implemented by October 02, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of nursing and personal support services for the home to meet the assessed needs of the residents.

In separate interviews with Inspector #594 it was identified by the Executive Director (ED), Director of Care (DOC) and the Assistant Director of Care (ADOC) that the staffing plan for the nursing department was as follows:

a) One RN for the building during the day, evening and night shifts

b) One RPN for each of five resident areas during the day and evening shift and one RPN for the building during the night shift

c) Two PSWs for each of four resident areas and three PSWs for one resident area during the day shift, two PSWs for each resident area during the evening shift and one PSW for each resident area during the night shift.

During the course of the inspection, the inspectors observed the following:

Inspector #593 arrived at the home at 0820h July 29, 2015. On the ground floor at the entrance to the elevators there were approximately 10 residents with ambulatory aids including walkers and wheelchairs waiting to use the elevators to return to their home units post breakfast. The button on the elevator was not pressed and so Inspector #593 pressed the button. The left side elevator returned to the ground floor and the doors opened, there was a resident in the doorway of the elevator which prevented access to the elevator. There were no staff members in the area to assist the residents with accessing the elevators. Another resident became upset at having to wait so they walked over to the resident in the elevator, who was in a wheelchair and started to push them off the elevator. The resident in the wheelchair became vocally upset and there were still no staff members in the area. Inspector #593 saw a housekeeping staff member and asked them to intervene. The housekeeping staff member intervened between the two residents, the resident in the wheelchair stayed in the elevator, another resident entered the elevator and the housekeeping staff member then sent the elevator up to the home units. The housekeeping staff member advised Inspector #591 that there should be a staff member in the area to assist the residents and then they left the area. The elevator then returned to the ground floor, the same resident in the wheelchair was still on the elevator blocking the doorway, no other resident could enter the elevator. A PSW then arrived at the elevators and began to assist residents back to their home areas. It was approximately 10 minutes from the time the inspector arrived to the time the PSW arrived to assist residents.

During an interview with Inspector #594 during the inspection, #S-124 stated that a resident had fallen that day. According to the Resident Adverse Event Internal Report, it was documented that the contributing factor leading to the fall was being short staff on the unit. The inspector interviewed the resident who stated that they had a fall while trying to provide their own care because they had been waiting five minutes for staff to help but they were busy due to the meal service and medication pass. According to the Nursing Floor Sheet reviewed by Inspector #594 and the DOC, the home was short staffed one day shift RPN and two day shift PSWs at the time of the fall.

On July 30, 2015, at 1145h, Inspector #594 observed the resident meal cart with four tray meals on one of the resident areas of the home. Inspector #593 observed that the four tray meals were not provided to residents until 1230h. The trays were not kept in a warmer during this time and staff were not observed to reheat meals before serving. During an interview with Inspector #593 July 30, 2015, #S-110 reported that there were several residents that receive a tray meal in their resident area and also required feeding assistance from staff. They added that they were running a PSW short that day, so there were only two PSWs on the unit. According to the Nursing Floor Sheet reviewed by Inspector #594 and the Scheduler, the home was short staffed one day shift PSW on one specific resident area, thereby pulling the a PSW from another area to fill the vacant staff position on this specific resident area, therefore leaving the other resident area short one PSW.

On July 30, 2015 at 1755h on a resident area of the home, during an interview with Inspector #594, #S-125 reported that they were working on the floor with an RPN but they were unaware of the location of the RPN. The inspector observed the RPN in the medication room. Over a ten minute period, the inspector observed four residents requesting help from #S-125. Resident #021 was yelling for a nurse and requesting a drink, #S-125 was then observed to leave resident #021 to provide assistance to another resident in their room; during this time, the RPN was attending to resident #022 who was requesting their medication. As resident #022 was following the RPN to the nursing station, resident #023 was trying to strike out at resident #022. While the RPN was occupied with resident #022 and #S-125 was occupied with the resident in their room, the inspector observed resident #023 yelling at a resident to get out of their room. According to the Nursing Floor Sheet reviewed by Inspector #594 and the Scheduler, the home was short staffed one evening shift RPN and one evening shift PSW on July 30, 2015.

During an interview with Inspector #594 on July 29, 2015, #S-110 and #S-114 stated that if the home is short staffed, baths don`t get done and because of a staff shortage that day, baths will not be completed. In an interview with the DOC, it was reported to Inspector #593 that if they are short staffed, they try to work smarter and not harder to try to get everything done. If they get to a point where they have to defer care they would look at each unit, for example tub baths take longer so they may do a sponge bath instead but this depends on who the resident is. The staff usually call the DOC in these situations and they walk through the care needed with the staff and prioritize. The DOC also added that the managers will also pitch in to help with care. When the DOC and ADOC work on the unit, this does not get captured on the staff schedule, so it may look like they are running short staffed. The inspector reviewed the Daily Missed Baths from July 01 to 27, 2015 where on July 04, in the evening, it was documented that no baths were completed on four resident areas because of staff shortage. On July 14, 2015, it was documented that no baths were completed in the evening on three resident areas because of staff shortage.

During a record review, Inspector #593 identified three progress notes which documented that resident #002 missed doses of medications because the staff member was not shown how to use the resident care equipment due to a staff shortage. Inspector #594 reviewed the Medication Administration Record for the resident to see progress notes for resident #002's medication administration times. According to the Nursing Floor Sheet reviewed by Inspector #594 and the DOC, the home was short staffed one RPN on this day.

Given that during the course of the inspection there was a documented pattern of registered nursing or direct care staff that were unable to be replaced on the staffing schedule, there were several incidents when resident care was affected by limited staffing and that through observation by the inspectors, resident care was not being provided, the licensee has failed to ensure that there is an organized program of nursing and personal support services for the home to meet the assessed needs of the residents.

Non-compliances have been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006, including a compliance order served May 29, 2014; pursuant to LTCHA, 2007 S.O. 2007, s. 8. (1) Every licensee of a long-term care home shall ensure that there is an organized program of nursing services for the

home to meet the assessed needs of the resident and an organized program of personal support services for the home to meet the assessed needs of the resident. [s. 8. (1)]

The decision to re-issue this compliance order was based on the scope which was widespread as multiple residents were affected, the severity which indicates actual risk/harm and the compliance history which despite previous non-compliance (NC) issued including two compliance orders, NC has continued for 30 months with this area of the legislation. (594)

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

Oct 02, 2015

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2014_380593_0001, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007,
s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order / Ordre :

(A1)
The licensee is required to prepare, submit and implement a plan for achieving compliance under s.11 (1) of the LTCHA:

(b) an organized program of hydration to meet the fluid needs of the residents.

The plan must include, but is not limited to:

* Re-training for nursing staff regarding the home s hydration program specifically related to the nourishment pass
* A process to ensure that residents attending activities receive nourishment at scheduled nourishment times
* Strategies to ensure that resident hydration is not affected if the home is operating outside of the regular nursing staff deployment
* The Food Service Manager and Registered Nursing Staff are to communicate and oversee the provision of between meal nourishments and address issues with this process as and if they arise

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by September 25, 2015 and fully implemented by October 02, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of dietary services that met the daily hydration needs of the residents.

On July 29, 2015 at 1017h, Inspector #593 observed the covered AM nourishment cart on a specific resident unit. Several residents were observed to be leaving the unit to attend the 1030h church service held in the dining room. These residents had not received a beverage from the AM cart prior to leaving the unit. At 1027h, a resident asked the inspector if they could have a juice or a coffee, at this time the nourishment cart was still covered and there were no staff members in the immediate

area. The resident was observed to then leave the area as there were no staff to provide them a beverage. At 1046h, the inspector observed a PSW uncover the nourishment cart and begin to offer the remaining residents a beverage.

On July 29, 2015 at 1015h, Inspector #593 observed the covered AM nourishment cart on on a specific resident unit. At 1025h, the cart was still observed to be covered and several residents were observed to leave the unit to attend the church service without being offered a beverage. At 1100h, the nourishment cart was still covered on this resident unit, no resident was observed to receive a beverage from the AM nourishment cart prior to the lunch service.

On July 29, 2015 at 1033h, Inspector #593 observed the church service commencing in the dining room on the ground floor. There were 13 residents observed to be in attendance and none of these residents were observed to be offered a beverage during or after the church service which ended just after 1100h.

On July 30, 2015 at 1043h Inspector #593 observed the covered AM nourishment cart on a specific resident unit. No resident had yet received a beverage as part of the AM nourishment pass and until the lunch service began.

During an interview with Inspector #593 July 31, 2015, #S-105 reported that the dietary staff usually bring the nourishment cart to the unit between 1000h and 1030h. #S-105 added, that the home's expectation is that PSWs provide residents a beverage immediately however they are usually busy and are often running short staffed so they are unable to do this.

A review of the home's document- Resident Meal and Snack Times found that the AM nourishment is scheduled for 1000h.

During an interview with inspector #593 August 5, 2015, the Food Service Manager (FSM) reported that the nourishment carts should be delivered to each unit by approximately 1000h. They need to make sure that the carts are delivered by this time especially if there is an activity scheduled for 1030h. The expectation is that the PSWs on each unit are to begin the nourishment pass as soon as they are able to. When the FSM was advised of the delays and lack of provision of the AM nourishment pass, they added that this should not be happening and they have had problems with this previously.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Non-compliances have been previously issued under inspection 2014_380593_0001, including a compliance order served August 7, 2014; inspection 2014_139163_0004, including a compliance order served March 27, 2014; and inspection 2013_139163_0019, including a compliance order served July 30, 2013; pursuant to LTCHA, 2007 S.O. 2007, s.11. (1) Every licensee of a long-term care home shall ensure that there is an organized program of nutrition care an dietary services for the home to meet the daily nutrition needs of the residents; and an organized program of hydration for the home to meet the hydration needs of residents. [s. 11. (1) (b)]

The decision to re-issue this compliance order was based on the scope which was a pattern as multiple residents were affected, the severity which indicates potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including three compliance orders, NC has continued for 24 months with this area of the legislation. (593)

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

Oct 02, 2015

Order # /
Ordre no : 007

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

Linked to Existing Order /
Lien vers ordre existant: 2015_269597_0003, CO #005;

Pursuant to / Aux termes de :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

LTCHA, 2007, 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 :

(A2)
The licensee is required to prepare, submit and implement a plan for achieving compliance under s.19 (1) of the LTCHA. This plan is to include:

1. Immediately implement strategies to be used to engage resident #018 regularly in a variety of scheduled and non-scheduled activities ensuring regular mental and physical stimulation to prevent boredom and possible trigger of abusive behaviours, with specific attention to before and after meals or any other time when staff are regularly busy such as end of shift.

2. Details of the steps to be taken to minimize inappropriate sexual behaviours displayed by resident #018 considering psychological, pharmaceutical, behavioural and physical interventions and steps to prevent resident #018 from being alone with female residents or in any situation where resident #018 could sexually abuse another resident.

3. The leadership team are to oversee the strategies implemented to prevent further incidents of sexual abuse and ensure that they remain current to resident #018 s needs and that they are consistently implemented by all staff.

Furthermore, the licensee is hereby ordered to comply with their own Policy #LP-C-20-ON: Resident Non-Abuse Ontario (dated September 2014) specifically related to the following sections but not limited to only them:

* Mandatory reporting
* Investigation of alleged, suspected or witnessed abuse
* Management of responsive behaviours
* Evaluation of the home s response to incidents of alleged, suspected or witnessed abuse

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by September 25, 2015 and fully implemented by October 02, 2015.

Grounds / Motifs :

1. A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018 towards resident #019.

During an inspection completed March 2015 under inspection 2015_269597_0003, a compliance order was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.19. the licensee failed to ensure that residents are protected from abuse by anyone. It was found that on three separate occasions, resident #018 was observed to abuse the same resident in the home. This follow up inspection was completed as a result.

A review of resident #018's progress notes, found that resident #018 abused resident #019 as they were ambulating past them in the hallway. Resident #018 was sitting in the hallway after returning to the resident area, contrary to their plan of care.

A review of the home's investigation into the incident found that #S-118 who witnessed the incident was interviewed and reported the following:

I was standing in the tubroom entrance way and I could see resident #018 in the

hallway behind the fan. I did not see them get off the elevator, so I cannot comment
how long they were there for. There were no staff members near resident #018 at this
time. Resident #019 came by and I saw resident #018 abuse resident #019. I addressed the situation
with resident #018. The PSW intervened and removed resident #018 from the area.

During an interview with Inspector #593 August 5, 2015, the DOC reported that resident #018 cannot ambulate independently. As a result, they require staff assistance to mobilize around the home. The DOC further reported that the incident of abuse toward resident #019 occurred when resident #018 was brought back to the resident area by staff from the dining room after lunch. Resident #018 was left by staff in a common area of the home. The DOC reported that this is not the protocol, they are to be taken down to another area and given an activity. The DOC added that there were other residents also coming back from lunch and so there was a crowd in this resident area. Resident #019 was navigating past resident #018 when they

abused them.

Inspector #593 reviewed resident #018's current care plan, and found the resident had a history of and potential for responsive behaviours as evidenced by incidence of abuse of co-residents and staff. Interventions in the care plan included one staff to escort to and from areas and staff to ensure resident #018 is not left in main care areas alone with residents.

A review of the resident's health care record found DOS documentation, implemented for 10 days, incomplete documentation on two of these days and the form was not completed for three of these days consecutively. A review of the resident's chart found "Q15 Minute Check" forms, implemented for four days and incomplete documentation on all four days.

A review of the resident's record found a history of specific responsive behaviours documented since 2012.

It was found that the incident of abuse towards a resident in the home was not reported immediately to the Director as per the 2007 LTCHA which states that abuse of a resident by anyone that resulted in harm or a risk of harm shall immediately report the suspicion and the information upon which it is based to the Director.

As evidenced by documented progress notes and staff interviews, resident #018 was known to exhibit responsive behaviours towards residents in the home. Furthermore, after a compliance order was served as a result of four incidents of abuse, an additional incident of abuse was allowed to occur toward a resident in the home. The licensee has failed to protect resident #019 within the home from resident #018 with known and documented abuse. [s. 19. (1)]

The decision to re-issue this compliance order was based on the severity which indicates actual harm and although the scope was isolated, there is a compliance history including one compliance order previously issued in this area of the legislation. (593)

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

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

Ministère 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

Oct 02, 2015

Order # / Ordre no : 008

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

Linked to Existing Order / Lien vers ordre existant: 2015_269597_0003, CO #006;

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee is required to prepare, submit and implement a plan for achieving compliance under s.24 (1) of the LTCHA. This plan is to include:

1. The strategies to be implemented to ensure that all staff members within the home are aware of the mandatory reporting requirements as per the LTCHA, 2007.
2. The strategies to be implemented to ensure that staff report all allegations of abuse immediately to the licensee as required by the home s policy #LP-C-20-ON: Resident Non-Abuse Ontario.
3. A process overseen by the leadership team to ensure that all abuse or alleged abuse of a resident is reported immediately to the Director regardless of day or time of day.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 347 Preston St, Suite 420, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be emailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by September 25, 2015 and fully implemented by October 02, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported abuse by resident #018 towards resident #019.

The CI was submitted however, the incident actually occurred two days earlier than when the CI was reported to the Director of the MOHLTC.

A review of the home's investigation records found that the incident was reported directly to the unit's RPN #S-120 and the charge RN #S-119 after the incident occurred. The RN completed an internal incident report that same shift however it was not clear when this incident was further reported to the Executive Director (ED)of the home.

A review of the home's policy: LP-C-20-ON Resident Non-Abuse dated September 2014, found that any staff member who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the ED of the home, or if unavailable, to the most senior supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the home's reporting requirements to ensure that the information is provided to the ED immediately. Furthermore, the same policy documents that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the MOHLTC- 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.

A review of the home's education records found that education was completed on the home's policy: LP-C-20-ON Resident Non-Abuse dated September 2014, for all staff during June and July 2015.

During an interview with Inspector #593 August 5, 2015, the DOC stated that the incident was reported to the RN in charge shortly after it occurred. The home's process is that the incident is then reported to the manager on call however sometimes there is a delay in this. The manager on call is to complete the CIS. The DOC further added that they run a report daily to view any incidents that have happened the previous day, however this incident occurred on a Saturday therefore the report would not have been generated until the following Monday. [s. 24. (1)] (593)

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the information upon which it was based to the Director.

In a complaint received by the Director it was stated that resident #006 was witnessed in an altercation with resident #007, and that resident #006 was observed to exhibit responsive behaviours frequently.

Inspector #594 reviewed resident #007's health care record and identified in a progress note, an entry stating that the resident sustained an injury after a resident

exhibited responsive behaviours toward resident #007. An internal incident report was completed.

The inspector reviewed the Resident Incident Internal Report , which stated that a resident exhibiting responsive behaviours toward resident #007 which resulted in an injury.

Upon review of resident #006's health care record, the inspector identified a progress note, which documented that resident #006 displayed responsive behaviours toward resident #007 which resulted in an injury, and specific interventions were listed in this progress note related to these behaviours.

The inspector reviewed CI reports submitted to the Director for resident abuse however this incident had not been reported as required.

The DOC reported to Inspector #594, that when Registered staff are notified about resident to resident abuse, the Registered staff are to document in progress notes and a Resident Incident Internal Report is to be completed. This completed form is then to be sent to the DOC/ADOC. If after hours, the Manager on Call is to be notified and they are to determine if the Director is to be notified, then complete the CI report if required.

During an interview with the Inspector #594, the ADOC reported that no CI report was submitted because the resident was not injured. The inspector reviewed the Resident Incident Internal Report with the ADOC who stated because the report was not completed thoroughly and because the ADOC wasn't there to witness the situation, they were not aware of all the facts including that resident #007 was injured. [s. 24. (1) 2.] (594)

3. The licensee has failed to immediately report to the Director where there were reasonable grounds to suspect abuse of a resident. During an interview with Inspector #594, it was reported by #S-126 that resident #006 injured another resident.

The inspector reviewed the Resident Incident Internal Report Forms from 2013 to 2015. Included with these forms was a hand written description from a direct care

staff member who stated that a student witnessed resident #020 displayed responsive behaviours toward resident #006 that resulted in resident #006 sustaining an injury.

The inspector reviewed reports submitted to the Director and failed to identify that the Director was notified.

In a statement received by the inspector, the DOC reported that the suggested altercation was listed in resident #006's chart as 'unwitnessed' and that there was no incident report located nor CI report submitted to the Director. The DOC further reported that staff responded (but were not present) and was indicated in the notation, that there was no injury description or bleeding, though the resident was given a bandaid, no hospitalization required.

The licensee failed to report immediately to the Director. This report to the Director was not contingent upon the licensee completing its investigation or validating the allegation.

A documented pattern of inaction regarding reporting certain matters, specifically resident abuse, to the Director on the part of the licensee was identified by inspectors during this inspection, July 27-31, 2015.

Non-compliance has been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015, pursuant to LTCHA, 2007 S.O. 2007, s. 24. (1) A person who has reasonable grounds to suspect that the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director 2. Abuse of a resident by anyone or neglect of the resident by the licensee or staff that resulted in harm or risk of harm to the resident. [s. 24. (1) 2.]

The decision to re-issue this compliance order was based on the scope which was a pattern as multiple residents were affected, the severity which indicates potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including one compliance order, NC has continued for 15 months with this area of the legislation. (594)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Oct 02, 2015

Order # /
Ordre no : 009

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

Linked to Existing Order /
Lien vers ordre existant: 2015_269597_0003, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee is hereby ordered to ensure that all drugs, unless otherwise ordered by the physician, are stored in an area or medication cart that is secure and locked.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

During a tour of the home July 28, 2015, Inspector #594 observed a prescribed medication at the bedside of resident #024. The inspector reviewed the Physician's Order for the resident which failed to identify that the medication was to be kept at the bedside.

Inspector #594 interviewed #S-120 who reported that the home's expectation is that no medications are to be at the resident bedside and that no resident in this home area have orders for medication at the bedside. The inspector showed #S-120 the medication at the resident's bedside and #S-120 stated that the resident recently returned from hospital and that the prescribed medication came from the hospital.

During an interview with the DOC, it was reported to the inspector that the home will try and discourage medications at the bedside and documentation such as a physician's order, must be in place if medication is kept with the resident.

Non-compliances have been previously identified under inspection 2015_269597_0003, including a compliance order served May 22, 2015 and inspection 2014_246196_0006, including a compliance order served May 29, 2014; pursuant to O.Reg 79/10, r. 129 (1) Every licensee of a long-term care home shall ensure that drugs are stored in an area or a medication cart, that is exclusively used for drugs and drug-related supplies and that is secured and locked. [s. 129. (1) (a)]

The decision to re-issue this compliance order was based on the severity which indicates a potential for actual harm and although the scope was isolated, there is a compliance history including two compliance orders previously issued in this area of the legislation. (594)

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

Sep 18, 2015

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

Ministère 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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 17 day of September 2015 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : GILLIAN CHAMBERLIN - (A2)

Service Area Office /
Bureau régional de services : Sudbury