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

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

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

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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
Aug 05, 2016;	2016_433625_0003 (A1)	005653-16	Resident Quality Inspection

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

KATHERINE BARCA (625) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home requested an extension to the compliance date of CO #004. An extension has been granted, changing the compliance due date from August 22, 2016 to September 30, 2016.

Issued on this 5 day of August 2016 (A1)

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

Original report signed by the inspector.

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

KATHERINE BARCA (625) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 29, March 1, 2, 3, 4, 7, 8, 9, 10 and 11, 2016.

Additional logs were completed concurrently with the RQI:

- a Critical Incident System report submitted for visitor to resident abuse;

- a Critical Incident System report submitted for a resident missing from the home for greater than three hours;

- a complaint regarding environmental concerns;

- a Critical Incident System report submitted for staff to resident abuse;

- a Critical Incident System report submitted for resident to resident abuse;

- a Critical Incident System report submitted for resident to resident abuse;

- a Critical Incident System report submitted for staff to resident abuse;

- a Critical Incident System report submitted for staff to resident abuse; and

- a Critical Incident System report submitted for neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Acting Director of Care (Acting DOC), the Associate Directors

of Care (Associate DOCs), the Environmental Services (ES) Manager, the Resident Services Coordinator (RSC), the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD), the Food Services (FS) Manager, the Recreation Services (RS) Manager, a Physiotherapist (PT), a Restorative Care Aide (RCA), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeper, residents and family members.

The Inspectors also reviewed resident health care records, various home's policies and procedures, employee training records, employee files, home's investigation files, council meeting minutes and maintenance contractor documents. Inspectors completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, home areas, meal services and conducted a tour of resident care areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

22 WN(s)
16 VPC(s)
4 CO(s)
2 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

On a specific date in February of 2016, Inspector #625 observed resident #031 return from an activity outside of the home.

On a specific date in March of 2016, resident #031 informed Inspector #625 that they were no longer permitted to engage in the activity by the home and had not engaged in the activity since the previous day. Resident #031 stated they were upset because they could no longer engage in the activity and asked Inspector #625 to speak with the home's management to determine why they could not longer engage in the activity, as the resident did not know why they were no longer permitted to engage in the activity by the home.

A review of resident #031’s health care record by Inspector #625 was conducted.

During an interview with Inspector #625 in March of 2016, the Executive Director (ED) confirmed that resident #031 was no longer permitted to engage in the activity by the home due to safety concerns. The ED stated that the resident engaged in the activity in excess of 20 times per day and that there had been a delay in obtaining and using an associated product to the activity as approval was required for the cost, and that the resident had not been permitted to engage in the activity by the home while waiting for the product to be in place. [s. 3. (1) 1.]

2. During an interview with Inspector #577 on a specific date in March of 2016, resident #012 stated that Housekeeper #129 yelled at them when they were looking for an item in their roommate's drawer weeks prior. Seven days later, resident #012 further revealed that they were still upset.

A review of resident #012's progress notes dated a specific date in February of 2016, by Inspector #577, identified that the resident was observed by a staff member going into their roommate's dresser drawer. The progress note stated that resident #012 was redirected, that education was provided to the resident regarding personal belongings and personal space, and that the resident was asked and reminded to not access other residents' belongings. The progress note also stated that resident #012 was upset.

During an interview with the Inspector #577, the Acting DOC stated that they had spoken with resident #012, that the resident was upset with Housekeeper #129 for accusing them of stealing an item. The Acting DOC indicated that, during their interview with Housekeeper #129, the Housekeeper denied accusing the resident of stealing and told the resident that they shouldn't be going into other residents' belongings. [s. 3. (1) 1.]

3. The licensee failed to ensure that the rights of residents were fully respected and promoted, including the right to be protected from abuse.

A Critical Incident System report was submitted to the Director in February of 2016, outlining an incident of abuse towards resident #001 by RPN #125.

Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

The home's policy "Resident Non-Abuse – Ontario - LP-C-20-ON" last revised September 2014, identified the definition of emotional abuse as that defined in Ontario Regulation 79/10 and provided examples including humiliation, intimidation, sarcasm, mocking, ridiculing, name calling, threatening or instilling fear.

A review of the home's investigation file by Inspector #196 determined that RPN #125 had psychologically abused resident #001, referred to the resident in a derogatory manner and stated that if the resident wasn't happy with the care then they should go somewhere else. [s. 3. (1) 2.]

4. A Critical Incident System report was submitted to the Director for an incident of visitor to resident abuse that occurred in January of 2016. The report indicated that resident #017 was moving towards resident #030 and their visiting family member. Resident #030's family member mocked resident #017's words and then moved resident #017 away from resident #030.

The Critical Incident System report was amended the next day to indicate that the ED had provided resident #030's family member with a letter that indicated the family member had violated the home's "Resident Non-Abuse" policy and the Residents' Bill of Rights, both of which had been provided to the family member upon the admission of resident #030 to the home. The report also indicated that resident #030's family member confirmed to the ED that the incident had occurred and that what they stated to resident #017 had been wrong.

Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or

infantilization that are performed by anyone other than a resident.

A review by Inspector #625 of the home's policy "Resident Non-Abuse – Ontario - LP-C-20-ON" last revised September 2014, identified the definition of emotional abuse as that defined in Ontario Regulation 79/10 and provided examples including humiliation, intimidation, sarcasm, mocking and ridiculing.

A review of a note from the ED signed in January of 2016 revealed that resident #017 was moving toward resident #030 while vocalizing prior to resident #030's family member responding as detailed in the Critical Incident System report.

A review of a letter dated January of 2016 from the ED to resident #030's family member stated that the family member mocked a resident and moved the resident away from the family member's direct area. The letter indicated that the family member's actions were in direct violation of the Residents' Bill of Rights and the home's "Resident Non-Abuse" policy, both of which the family member was aware of when admitting resident #030 to the home, and that the behaviour was classified as emotional abuse according to the LTC Homes Act, 2007.

During an interview with Inspector #625 on March 10, 2016, the ED confirmed the details in the letter dated January of 2016, including that the family member emotionally abused resident #017. [s. 3. (1) 2.]

5. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right not to be neglected by the licensee or staff.

A Critical Incident System Report was submitted to the Director in March of 2016, outlining an incident in which resident #003 requested assistance from the evening staff. The report indicated that the staff member responded to the resident that they would get another staff member to assist with the provision of care but did not return. The report identified that the resident reported the incident to the staff on the night shift who then provided the resident with assistance.

A review of the resident's care plan by Inspector #196 identified that the resident required assistance with some aspects of care, and listed as an intervention that staff were to provide the assistance to the resident per their request.

A review of the home's investigation file, including interview notes with PSW #126, identified that the resident requested assistance and PSW #126 informed the

resident that they could not provide the assistance as the PSW was alone. The interview notes indicated that PSW #126 confirmed that they did not request assistance from the RPN or the RN who were working at the time.

The home's policy "Resident Non-Abuse - Ontario - LP-C-20-ON" last revised September 2014, defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being - including inaction or a pattern or inaction that jeopardizes the health, safety or well-being of one or more residents. Examples listed include unreasonably ignoring a call for assistance and refusing to provide assistance to the bathroom when the resident requests or requires such assistance.

During an interview conducted by Inspector #196 on March 8, 2016, the ED reported that the home's investigation identified that PSW #126 neglected to provide assistance when asked by the resident. [s. 3. (1) 3.]

6. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A review of resident #023's health care record by Inspector #625 identified a progress note dated a specific date in February of 2016, entered by RPN #122, that indicated, after providing the resident a treatment, a health concern was identified. The RPN notified RN #121 and made a notation on the "Doctor's Communication Form" of the finding.

A second progress note dated a specific date in February of 2016 was entered by RN #121 and had been left for the Registered Nurse (EC) requesting an order for treatment.

A review of the resident's progress notes, "Doctor's Communication Form" and "Physician's Digiorder" by Inspector #625 could not identify that an assessment of, or treatment for, the resident had been provided to the resident in response to the progress notes dated a specific date in February of 2016, identifying that follow-up was required.

During an interview with Inspector #625 on March 11, 2016, Associate DOC #104 reviewed resident #023's health care record and stated that they could not locate follow-up documentation related to the assessment of, treatment for, or current

status of resident #023. During a second interview with Associate DOC #104 later the same day, they reiterated that they could not locate any indication in the resident's health care record that follow-up assessment and treatment of the concerns identified by registered nursing staff in the progress notes dated a specific date in February of 2016 had occurred. [s. 3. (1) 4.]

7. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On March 8, 2016 at 1027 hours, in the presence of the Associate DOC #104, Inspector #625 observed an unattended computer screen displaying personal health information for resident #027. Information that was immediately visible included the resident's date of birth, most recent vital signs and tasks where PSWs were to document the provision of care for resident #027. The terminal was logged into by PSW #127 but no staff were visible.

While Inspector #625 waiting by the unattended computer screen, Associate DOC #104 located PSW #127 who stated to the Inspector and Associate DOC #104 that they had intended to return to document on residents. The Associate DOC #104 stated that personal health information was visible on the screen and that the screen must be locked or logged off of should staff leave the area, so that it cannot be viewed by others. [s. 3. (1) 11. iv.]

8. On March 10, 2016 at 1949 hours, Inspector #625 observed an unattended medication cart located on the sixth floor, directly across from the elevator. The screen, logged into by RPN #128, displayed information for resident #032. No staff were present at, or visible from, the medication cart. Information displayed included specified medications, doses and administration instructions for resident #032's medications.

At approximately 1951 hours, RPN #128 exited a resident's room several doors away from the medication cart and walked to the medication cart where the Inspector stood. The RPN explained that they had administered medications to a resident and had left the monitor unlocked. The RPN stated that the monitor should be locked when staff leave the medication cart.

During an interview with Inspector #625 on March 11, 2016, Associate DOC #104

stated that the screen that displayed resident #032's personal health information, should have been logged off or locked when RPN #128 left the medication cart. The Associate DOC #104 stated that, should a staff member walk away from a computer screen, resident personal health information should not be displayed. [s. 3. (1) 11. iv.]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: the right not to be neglected by the licensee or staff; and the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. (a) The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During an interview on March 7, 2016 with Inspector #196, resident #002 and their spouse reported that, on a daily basis, a specific component of oral care was provided in the evening and in the morning. They also reported that a second specific component of oral care was not done daily.

The current care plan was reviewed by Inspector #196 and, under the focus of oral hygiene, it was indicated that the resident required staff assistance with oral care as evidenced by the resident's inability to complete the task independently due to specific health conditions. The interventions did not include the second specific component of oral care.

During an interview with Inspector #196 on March 9, 2016, the Associate DOC #104 confirmed that the care plan should have had the second specific component of oral care to be provided twice daily noted in the care plan, in addition to the first specific component of oral care.

(b) A review of resident #024's current care plan related to oral hygiene by Inspector #625 indicated that the resident required assistance with mouth care by staff, that staff were to provide a specific component of oral care if indicated by a

specific criteria, that the resident had a second specific component of an oral care routine to be completed overnight and in the morning, and identified communication techniques to use.

A review of the home's policy "Oral Assessment and Care - LTC-H-20" last revised May 2013, by Inspector #625, indicated that residents would receive or be cued to perform oral care at least twice daily and that each resident's individualized oral care needs would be documented in their care plan.

During an interview with Inspector #625, PSW #116 stated that they were familiar with resident #024's oral care routine. PSW #116 stated that the resident had specific oral care provided overnight, in the morning and at night, that they resident would notify staff of preferences related to the oral care as their as their choice differed nightly. The PSW stated that, if a staff member who was unfamiliar with resident #024 reviewed the care plan, they would not know to provide the resident with a the second specific component of oral care regularly, and would only do so if the specific criteria was identified.

During an interview with Inspector #625, PSW #112 reviewed resident #024's care plan related to oral hygiene. When asked how the PSW would provide oral care to the resident based on the care plan, they stated that, as they did not work during the day shift, they would not know how to provide oral care to the resident in the morning from what was identified in the care plan. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

On March 3 and March 7, 2016, Inspector #625 observed resident #024 in bed with two partial bed rails in the raised position.

A review of resident #024's current care plan did not indicate that bed rails were in use.

A review of the most current "Side Rail and Alternative Equipment Decision Tree - LTC-10-05-ON" completed in July of 2015 by Restorative Care Aid #118 indicated that resident #024 used two quarter bed rails in a specific type of bed.

During an interview with Inspector #625 on March 7, 2016, PSW #112 stated that the resident used bed rails. PSW #112 could not locate the use of bed side rails on

the resident's Kardex. PSW #112 located the use of bed rails for resident #024 listed as a task for PSWs to sign each shift, to indicate that the bed rails were in place.

During an interview with Inspector #625 on March 8, 2016, Restorative Care Aid #118 confirmed that resident #024 requested the use of bed side rails prior to receiving a specialized bed in January of 2016. Restorative Care Aid #118 could not confirm if resident #024 continued to request the use of bed side rails in the new specialized bed and stated that a new "Side Rail and Alternative Equipment Decision Tree - LTC-10-05-ON" form should have been completed when the resident changed beds but was not done.

During an interview with Inspector #625, the Associate DOC #102 verified that the use of bed rails was not listed on resident #024's Kardex or care plan, even though they were in use.

During interviews with the Acting DOC on March 8, 2016, they confirmed that the use of bed rails for resident #024 had been included as a task for PSWs to complete, but not been listed in the resident's care plan or on the Kardex as it should have been. [s. 6. (1) (c)]

3. A review of resident #024's health care record by Inspector #625 included:

- two different entries for a clinical procedure listed on the January, February and March 2016 Medication Administration Records (MARs). The first entry indicated that a specific clinical procedure (including the size of the equipment) was to be completed, and the second entry instructed staff to adjust the size of the equipment if needed to prevent an undesirable outcome. The first entry also instructed staff to complete the procedure each month on a specific date as needed, and the second entry instructed staff to complete the procedure monthly, on no identified date, as needed;

- a "Physician's Order Review" dated February of 2016, that ordered a clinical procedure be performed when needed. The order did not specify the information listed on the MARs such as if the procedure was to occur each month on the a specific date as needed, if the procedure was to occur monthly as needed on no specific date, if staff were to use a specific size of equipment, or if staff were to adjust the equipment size if needed to prevent an undesirable outcome; and

- a care plan related to the use of clinical equipment, last reviewed in February of 2016 that directed staff to the Treatment Administration Record (TAR) for clinical equipment information, yet the TARs for November of 2015, December of 2015, January of 2016 and February of 2016, did not contain this information.

During an interview with Inspector #625 on March 7, 2016, RPN #115 stated that resident #024's clinical procedure was completed as needed.

During an interview with Inspector #625 on March 7, 2016, the Associate DOC #104 reviewed the "Physician's Order Review" dated February of 2016 that indicated resident #024's clinical procedure was to be completed when needed. They also reviewed the current MAR that listed two different clinical procedure instructions. The Associate DOC #104 stated there were discrepancies in the information related to clinical procedure in resident #024's health care record.

During an interview with Acting DOC, they stated that the physician's order and the MAR for resident #024 did not provide clear direction to the staff on how to complete the clinical procedure for the resident. [s. 6. (1) (c)]

4. A review of resident #022's health care record by Inspector #625 identified a progress note dated November of 2015 that indicated altered skin integrity on a specific area was resolved.

A review of resident #022's TAR for March 2016 listed a treatment for altered skin integrity on a second area, but reflected that the treatment was no longer required after a specific date in March of 2016.

A review of resident #022's current care plan continued to indicate that the resident had unresolved altered skin integrity on both areas.

During an interview with Inspector #625 in March of 2016, Associate DOC #102 confirmed that resident #022's altered skin integrity of one area was resolved in November of 2015 as the progress note stated, but that the care plan was not updated at the time as it should have been. The Associate DOC #102 also stated that resident #022's altered skin integrity of the second area had resolved on a specific date in March of 2016 as was reflected on the March 2016 TAR, but that the current care plan had not been updated as it should have been. [s. 6. (1) (c)]

5. During a review of resident #021's current care plan by Inspector #625, an

intervention was identified indicating that a safety device was in use to prevent the resident from falling.

A review of resident #021's health care record identified a progress note dated December of 2015, entered by RPN #117, that stated that resident #021's family had requested the safety device be removed, and that a message was left for the Restorative Care Aide (RCA) with this information. A second progress note dated December of 2015 was entered by RCA #118 that stated the safety device was removed as per the family's request.

During an interview with Inspector #625 on March 8, 2016, the Acting DOC stated resident #021's current care plan listed the use of the safety device for the resident to prevent the resident from falling. The Acting DOC confirmed with RCA #118 that resident #021's family had requested the safety device be removed and that the RCA had removed the device at that time, from the the area where it had been in use.

The Acting DOC accompanied Inspector #625 to the resident's room and confirmed that the safety device was not present in the area where it had been in use, although the use of the safety device was still identified in resident #021's current care plan. [s. 6. (1) (c)]

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

Inspector #625 reviewed resident #022's current care plan that identified that staff were to refer to the Treatment Administration Record (TAR) for the resident's current treatment plan related to the resident's medical condition in two specific locations of their body.

A review of resident #022's TARs from a specific date in December of 2015 to a specific date in March of 2016, identified that a medical treatment was to be completed on three specific days per week. The TARs were not signed to indicate the medical treatments were completed on:
- three specific dates in December of 2015, or 23 per cent of the time;
- two specific dates in January of 2016, or 15 per cent of the time; and
- one specific dates in March of 2016, or 25 per cent of the time.

A review of resident #022's TARs from a specific date in December of 2015 to a

specific date in March of 2016, identified that a medical treatment was to be completed on two specific days per week. The TARs were not signed to indicate the medical treatments were completed on:
- two specific dates in December of 2015, or 25 per cent of the time;
- two specific dates in January of 2016, or 22 per cent of the time; and
- one specific date in March of 2016, or 50 per cent of the time.

During an interview with Inspector #625 on March 22, 2016, Associate DOC #102 stated that staff were required to sign the TAR to indicate that treatments had been completed. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 002 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.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following is documented: the provision of the care set out in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On March 1, 2016 Inspector #625 observed the grab bar in resident #023's washroom to be loose and to have one screw coming out from the wall.

A review of resident #023's care plan last reviewed in February of 2016, identified that the resident required the use of the grab bar for safety and mobility.

During an interview with Inspector #625 on March 11, 2016, PSW #110 viewed the grab bar in resident #023's washroom, stated it was loose, and proceeded to move the grab bar approximately 10 cm from side to side. PSW #110 identified a crack in the drywall and stated that it had occurred as the result of the pressure of the grab bar when being used.

During an interview with Inspector #625 on March 11, 2016, the Environmental Services (ES) Manager stated that home's staff were required to fill out a "Physical Plant Service Requisition" to notify the Maintenance Department of any needed repairs and that there were no outstanding "Physical Plan Service Requisition" forms related to grab bars at that time.

The ES Manager and Inspector #625 attended resident #023's washroom and assessed the grab bar. The ES Manager stated that the grab bar was loose and coming out from the drywall, that the drywall was cracking as a result of the grab bar not being secured, and that a plate may need to be installed behind the grab bar to better secure it. [s. 15. (2) (c)]

2. On a specific day in January of 2016, an incident occurred which resulted in a sewer back up across the home's crawl space. The invoice from the service provider indicated that there was a compromised cast iron fitting and a drain line that had rotted open.

During an interview with Inspector #196 on March 6, 2016, the Environmental Services (ES) Supervisor stated that a "bad odour" had occurred the day after the sewage leak which could be smelled in the elevators, a hallway and specific rooms on the main floor. A service provider attempted to neutralize the air over a period of three weeks but the odour returned after a couple of days requiring retreatments. A second service provider was contacted and determined that an exhaust fan located in the crawl space, which was required to run continuously, was not operational. The ES Supervisor stated that they did not know how long the fan had not been operational but, since being employed in the home for over three and a half years, they had no knowledge of the fan, or of any maintenance performed on the fan. The ES Supervisor stated that preventative maintenance had not been conducted on the crawl space in the past.

During an interview regarding the maintenance of plumbing and drains in the crawl space conducted by Inspector #196 on March 11, 2016, the Executive Director (ED) produced a document titled "Halsall Draft Property Condition Assessment" for the home dated November of 2011. Within the document, it identified that "The crawl space has an exposed dirt floor. The exposed pipes and structure have significant surface corrosion, likely due to vapour transfer from the soil. We recommend that the dirt floor be covered with heavy duty polyethylene to minimize vapour transfer. We have included a budget to repair the crawl space".

Further review of the "Halsall Draft Property Condition Assessment" identified that "In June 2009, we noted that one of the top chords in the crawl space has a kink and this would be considered a structural failure of the joist(s) at this location which can translate into sagging or cracking of the supported floor around this location. We were not able to visually confirm during our site visit if this joist was repaired but according to the ESM, this structural failure has not been addressed. We recommend further investigation of the damaged joist. We have also included a preliminary repair allowance".

During the interview with Inspector #196 on March 11, 2016, the ED reported, after consulting with the licensee, that the structural joist failure had not been repaired in

2012, that funds had been budgeted to investigate the concerns in the crawl space in 2013, but that no further investigative work was done in the crawl space, and that the recommendations identified in the "Halsall Draft Property Condition Assessment" had not been implemented. The ED confirmed that the crawl space had not been inspected since the assessment was completed in 2011. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. The licensee has failed to ensure that all residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

Critical Incident System report was submitted to the Director in relation to reported abuse by resident #015 towards resident #017 in February of 2016. The report specifically indicated that resident #015 attempted to sexually abuse resident #017.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual

exploitation that is directed towards a resident by a licensee or staff member, or, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of the home's policy "Resident Non-Abuse - Ontario - LP-C-20-ON" last revised September 2014, defined sexual abuse as indicated in Ontario Regulation 79/10 and listed examples as unwanted touching or molestation that is sexual in nature.

A review of resident #015's progress notes by Inspector #577 identified three incidents of inappropriate sexual behaviours exhibited towards residents and four incidents of inappropriate sexual beahviours exhibited towards staff, from 2014 to 2016.

A review of resident #015's care plan found that the resident had responsive behaviours as evidenced by inappropriate sexual behaviour exhibited towards staff and other residents. Interventions were listed in the care plan.

A record review of resident #015's chart revealed that the resident was assessed by an outside agency in 2012, for inappropriate sexual behaviours made towards staff. The resident was discharged from the program in the summer of 2012. In 2013, the resident was referred again for sexual abuse of residents on a daily basis, and attempting to exhibit sexually inappropriate behaviours to visitors and staff. In winter of 2014, the resident was discharged from the program. During the summer of 2015, a consultation by a psychiatrist was done and determined that resident was no longer causing significant concerns and the outside agency was no longer involved.

A review of resident #015’s chart found “Sexually Inappropriate Behaviour Tracking Sheet" forms were implemented for 14 days in February of 2016 and again for two days in February of 2016 and 13 days in March of 2016,to closely monitor the resident’s behaviour.

On March 10, 2016 Inspector #577 observed resident #017 enter the TV lounge and seat themself beside resident #015 on two occasions, which left the residents unsupervised by home's staff for one to two minutes each time.

During an interview with Inspector #577, PSW #134 and RPN# 131 stated that

resident #015 stayed in the TV lounge area and was supervised during a specific activity, and that these interventions were in place to keep resident #015 away from other specific residents.

During an interview with the Associate DOC #104, they confirmed that resident #015 stayed in their room, was always was supervised during a specific activity, could sit in the TV lounge when specific residents were not in the area, and that staff were to know resident #015's whereabouts at all times.

During an interview with the Executive Director (ED), they confirmed that it was the expectation of the home that all residents be protected from abuse and the home failed to protect resident #017 from abuse by resident #015. The ED further confirmed that staff should be monitoring and checking the whereabouts of resident #015 at all times. [s. 19. (1)]

2. A Critical Incident System (CIS) report was submitted in March of 2016 for an incident of staff to resident neglect that had occurred three days prior. The report indicated that resident #028 had repeatedly asked Personal Support Worker (PSW) #119 for assistance with care and that PSW #119 did not respond to the resident's requests. PSW #120 heard the resident's unanswered requests for assistance and later provided assistance to resident #028, after completing care with another resident.

A second Critical Incident System report was submitted for an incident identified in the report as improper or incompetent treatment of a resident that results in harm or risk of harm to a resident that occurred one day after the incident detailed in in the first identified report. The report indicated that the same employee identified in the first CIS report, PSW #119, was providing care to resident #021. As PSW #119 was assisting the resident, the PSW hurt the resident.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The regulation defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain and states that physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

A review of the home's policy "Resident Non-Abuse - Ontario - LP-C-20-ON" last revised September 2014, defined neglect as identified in Ontario Regulation 79/10 and listed examples as unreasonably ignoring a call for assistance and refusing to provide assistance to the bathroom when the resident requests or requires such assistance. The policy defined physical abuse as identified in Ontario Regulation 79/10 and listed rough handling as an example.

A review by Inspector #625 of the investigation file for the first incident of neglect that occurred in March of 2016 included documents that identified that resident #028 called out repeatedly, with increasing volume, that they needed assistance, and that PSW #119 did not respond to the resident's requests for assistance.

A review by Inspector #625 of the investigation file for the incident of physical abuse that occurred in March of 2016 included documents that identified that resident #021 had stated that PSW #119 was rough when assisting the resident with a specific aspect of the resident's care, and that PSW #119 had hurt the resident while providing care to them. The resident was also documented as saying that there had been previous incidents with PSW #119 that the resident did not report, the resident did not want PSW #119 to provide specific care to them in the future, and that the resident thought that PSW #119 was not patient enough to provide gentle care.

A review of the home's policy "Resident Non-Abuse – Ontario – LP-C-20-ON" revised September 2014, identified 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 Executive Director (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. The policy also identified that if a staff member was alleged, suspected or witnessed to have abused and/or neglected a resident, the staff member would be immediately suspended from their duties and required to leave the premises pending investigation.

A review by Inspector #625 of the investigation files for for the first Critical Incident System report, related to staff to resident neglect, and the second report, related to staff to resident physical abuse, identified that, in March of 2015, PSW #120 witnessed the neglect of resident #028 by PSW #119 and did not notify the Executive Director or the most senior Supervisor on shift at that time. PSW #119

continued to attend work and, one day following the first incident of abuse, the PSW physically abused resident #021. RN #121, the most senior Supervisor on shift at the time, was notified 48 hours after the incident of neglect and 30 hours after the incident of physical abuse had occurred. The Executive Director was notified by email 53 hours after the incident of neglect and 35 hours after the incident of physical abuse had occurred.

A review by Inspector #625 of PSW #119's employee file revealed documents indicating that the PSW was hired by the home in 2015; PSW #119 did not have a diploma from a Personal Support Worker program; that PSW #119 had a diploma from another program, but was not a registered member of that program's profession; and that PSW #119 had been issued discipline for improper care of a resident that occurred in February of 2016.

During interviews with Inspector #625 on March 9, 2016, the Executive Director (ED) stated that staff did not report the first incident of resident neglect that occurred in March of 2016 immediately to the ED as was required, resulting in the ED not being notified, and the employee continuing to attend work the following day, when the incident of physical abuse occurred. The ED also stated that PSW #119 did not meet the qualifications for Personal Support Workers listed in Ontario Regulation 79/10 section 47. The ED confirmed that PSW #119 was hired into a personal support worker position for which they were not qualified. The ED also stated that, had PSW #119 not been hired, the neglect of resident #028 and the physical abuse of resident #021 on two separate dates in March of 2016 would not have occurred. [s. 19. (1)]

3. A Critical Incident System report was submitted for an incident of resident to resident abuse that occurred in February of 2016. The report indicated that, during a recreation program, contractor #123 witnessed resident #025 touch resident #026 in a sexual nature. The report stated that contractor #123 did not intervene when witnessing this interaction.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The Long-Term Care Homes Act, 2007 defines the term "staff", in relation to a long-term care home, to mean persons who work at the home and includes persons working in the home persuant to a contract or agreement with the licensee, or persuant to a contract or agreement between the licensee and a third party.

A review by Inspector #625 of the home's "Resident Non-Abuse – Ontario – LP-C-20-ON" policy last revised September 2014, identified sexual abuse as defined in Ontario Regulation 79/10 and provided examples including unwanted touching or molestation that is sexual in nature. The policy also indicated that all staff members and volunteers would be required to read the "Resident Non-Abuse - Ontario" policy and sign the "Resident Non-Abuse Acknowledgment Form" upon hire, before commencing work.

The policy also identified staff and volunteer training was to be completed prior to performing responsibilities and annually thereafter, and was to include training on The Residents' Bill of Rights, the "Resident Non-Abuse National Policy", the "Resident Non-Abuse Acknowledgment Form", situations that may lead to abuse and neglect, how to avoid such situations and the duty to make mandatory reports of abuse and neglect. The policy stated that all staff and volunteers interacting with resident on a regular basis were to be trained on procedures and interventions to assist and support residents who have been abused or neglected, or allegedly abused and neglected and to deal with persons who have abused or neglected, or allegedly abused or neglected.

A review by Inspector #625 of the home's investigation file for the incident of sexual abuse that occurred in February of 2016, included a statement from contractor #123 that described the touch of a sexual nature of resident #025 to resident #026.

The investigation file also contained an email from the home's Executive Director (ED) describing an incident with resident #025 that occurred immediately prior the incident with resident #026.

During an interview with Inspector #625 on March 10, 2016, the Executive Director (ED) stated that, in February of 2016, resident #025 exhibited sexually inappropriate behaviour. The ED confirmed that contractor #123 witnessed the sexual abuse occur between residents #025 and #026, but did not notify RPN #113 of the incident until the program was completed.

The ED also stated that contractor #123 attended the home in a paid capacity two times per month, and as a volunteer two times per year, but had not receive training as required in the Long-Term Care Homes Act, 2007 sections 76 or 77, as required for staff and volunteers at the home, respectively. The ED also stated that contractor #123 had not received training on the Residents' Bill of Rights or the home's policy to promote zero tolerance of abuse and neglect of residents. The ED confirmed that the training should have been provided to contractor #123 but was not. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

DR # 002 – 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy "Fall Interventions Risk Management (FIRM) Program - LTC-E-60" last revised March 2014, stated that residents' risk for falls would be reassessed quarterly and annually based on immediate risk criteria.

A review by Inspector #625 of resident #021's health care record determined that one Falls Risk Assessment Tool (FRAT) was completed in the summer of 2015, corresponding with the resident's admission to the home.

During an interview with Inspector #625 on March 8, 2016, the RAI Coordinator #106 confirmed that the "Falls Interventions Risk Management (FIRM) Program" indicated that a falls risk assessment would be completed quarterly. They identified that the falls risk assessment referred to in the program was the FRAT, and that the home's practice was not for the FRAT to be completed quarterly, but only on admission and annually thereafter.

During an interview with Inspector #625 on March 9, 2016, the Acting DOC stated that the home's practice, as directed by the licensee, was to complete the falls risk assessment on admission, annually and as a change in condition deemed it was necessary. The Acting DOC stated that the policy was being revised and the new draft policy did not include the completion of a quarterly falls risk assessment (or FRAT) as indicated in the home's current policy. The Acting DOC acknowledged that the home's staff had access to the home's current policy, which reflected the completion of falls risk assessments quarterly was to occur, but that the home did not complete falls risk assessments quarterly. [s. 8. (1) (a),s. 8. (1) (b)]

2. The policy "Fall Interventions Risk Management (FIRM) Program - LTC-E-60" last revised March 2014, stated that, if a fall was not witnessed, a neurological assessment would be initiated, the resident would be monitored for 72 hours and neurological monitoring documentation for 72 hours would be completed.

A review by Inspector #625 of resident #021's health care record identified a progress note detailing an unwitnessed fall that occurred on a specific date in February of 2016. Progress notes were entered related to the fall and assessment

of the resident twice on the specific date of the fall in February of 2016; three times on day following the fall on a specific date in February of 2016, and twice on two days following the fall on a specific date in February of 2016. The last progress note related to resident #021's fall was entered two days following the date of the fall in February if 2016 at 1338 hours.

A review of resident #021's health care record included a review of a "Neurological Flowsheet" that indicated assessments were to be completed every 30 minutes for two hours, every one hour for six hours, every four hours for six hours and every eight hours for 56 hours. The last entry was documented two days after the date of the fall at 1630 hours, 48 hours after the initial entry. The final three entries, to be completed eight hours apart on a specific date three days after the fall in February of 2016, were blank.

During an interview with Inspector #625 on March 8, 2016, RPN #113 stated that the "Neurological Flowsheet" was to be completed over a 72 hour period but that resident #021's flowsheet initiated on the date of their fall on a specific date in February of 2016 was not complete as three entries were missing.

During an interview with Inspector #625 on March 11, 2016, Associate DOC #104 stated that the "Neurological Flowsheet" was required to be completed in it's entirety for 72 hours after applicable resident falls. [s. 8. (1) (a),s. 8. (1) (b)]

3. A review by Inspector #625 of the "Fall Intervention Risk Management (FIRM) Program - LTC-E-60" last revised March 2014, indicated that, if a fall was not witnessed, a neurological assessment would be initiated, the resident would be monitored for 72 hours and neurological monitoring documentation for 72 hours would be completed.

A review of the "Neurological Flowsheet" dated a specific date in February of 2016 for resident #023, identified by the Associate DOC #104 as the neurological assessment referred to in the policy, listed neurological vital signs completed from the date of the fall on a specific date in February of 2016, to two days after the date of the fall in February of 2016 at 1900 hours. The last column was blank and the sheet did not reflect neurological monitoring of the resident for 72 hours, but for 62 hours.

During an interview with Inspector #625 on March 11, 2016, Associate DOC #104 stated that the "Neurological Flowsheet" was missing the final entry to reflect that

resident #023 was neurologically assessed for 72 hours after their fall. The Associate DOC #104 was not able to locate or provide documentation to reflect that a neurological assessment was conducted for 72 hours after the resident's fall. [s. 8. (1) (a),s. 8. (1) (b)]

4. (a) The policy "Skin and Wound Program - LTC-E-90" last revised August 2015, stated that, upon closure of skin breakdown, documentation in the interdisciplinary progress notes and the resident care plan would be completed as per regulatory standards.

A review by Inspector #625 of resident #022's health care record included: a current care plan that indicated the resident had altered skin integrity on two specific areas; a progress note dated a specific date in November of 2015 that indicated the altered skin integrity of the first area had resolved; and a TAR dated March of 2016 that indicated the treatment to the altered skin integrity of the second area had been discontinued after a specific date in March of 2016.

During an interview with Inspector #625, Associate DOC #102 confirmed that the policy was not followed as the altered skin integrity on both specific areas had resolved and the current care plan had not been updated to reflect this for either altered skin integrity, and that one of the resolved altered skin integrity areas to the second area had not been documented in the progress notes.

(b) The policy "Skin and Wound Program - LTC-E-90" last revised August 2015, stated that wounds would be photographed initially and at least monthly as per best practice.

A review by Inspector #625 of resident #022's photographs of a two areas of altered skin integrity, from October of 2015 to February of 2016, identified that photographs were missing for the month of December for both areas of altered skin integrity.

During an interview with Associate DOC #102, they confirmed that the policy was not followed as two areas of altered skin integrity were not photographed for the month of December of 2015.

(c) The policy "Skin and Wound Program - LTC-E-90" last revised August 2015, stated that, the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" was to be completed with every dressing change, at a minimum of

every 7 days.

(i) Resident #022's Treatment Administration Record (TAR) listed a medical treatment for an area of altered skin integrity completed on eight specific dates in December of 2015. A review of the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" for resident #022's area of altered skin integrity for December of 2015 identified wound assessments were not completed during treatments on three specific dates in December of 2015, or 37 per cent of the time.

Resident #022's TAR listed a medical treatment for an area of altered skin integrity completed on 11 specific dates in January of 2016. A review of the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" for resident #022's area of altered skin integrity for January of 2016 identified wound assessments were not completed during treatments that occurred on four specific dates in January of 2016, or 36 per cent of the time.

Resident #022's TAR listed a medical treatment for an area of altered skin integrity completed nine specific dates in February of 2016. A review of the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" for resident #022's area of altered skin integrity for February of 2016 identified wound assessments were not completed during treatments that occurred on two specific dates in February of 2016, or 22 per cent of the time.

(ii) Resident #022's TAR listed a medical treatment for an area of altered skin integrity completed on four specific dates in December of 2015. A review of the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" for resident #022's area of altered skin integrity for December of 2015 identified wound assessments were not completed during treatments that occurred on two specific dates in December of 2015, or 50 per cent of the time.

Resident #022's TAR listed a medical treatment for an area of altered skin integrity completed on six specific dates in January of 2016. A review of the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" for resident #022's area of altered skin integrity for January of 2016 identified wound assessments were not completed during treatments that occurred on two specific dates in January of 2016, or 33 per cent of the time.

Resident #022's TAR listed a medical treatment for an area of altered skin integrity completed on six specific dates in February of 2016. A review of the "Treatment

Observation Record (TOR) - Ongoing Wound Assessment" for resident #022's area of altered skin integrity for February of 2016 identified wound assessments were not completed during treatments that occurred on three specific dates in February of 2016, or 50 per cent of the time.

During an interview with Associate DOC #102, they confirmed that the policy "Skin and Wound Program -LTC-E-90" last revised August 2015, was not followed as the "Treatment Observation Record (TOR) - Ongoing Wound Assessment" was not completed for all treatments signed for in the Treatment Administration Record. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

On March 4, 2016, Inspector #196 observed resident #003 sleeping in a specialized type of bed with bilateral upper bed rails elevated.

During an interview conducted by Inspector #196 on March 8, 2016, Restorative Care Aide (RCA) #118 reported that the resident was provided with a new specialized type of bed on a specific date in March of 2016 and that they were about to conduct a bed system assessment on this day. The RCA confirmed that the resident had been in the new bed for five days prior to having the assessment conducted.

On March 9, 2016, Inspector #196 conducted an interview with Associate DOC #104 who reported that residents were to be assessed at the time that bed rail use was initiated and confirmed that resident #003 received a specialized type of bed on a specific date in March of 2016. [s. 15. (1) (a)]

2. On March 3 and March 7, 2016, resident #024 was observed by Inspector #625 laying in a specialized type of bed with bilateral upper bed rails elevated.

A review of the home's policy "Side Rails" effective October 2013, stated that all residents using side rails would be assessed for their need for side rails, the associated risk with the utilization of side rails and referenced use of the "Side Rail and Alternative Equipment Decision Tree".

During an interview with Inspector #625 on March 8, 2016, the Acting DOC stated that the Restorative Care Aide #118 was to complete "Side Rail and Alternative Equipment Decision Tree" forms for all residents using bed rails.

During an interview with Inspector #625 on March 8, 2016, Restorative Care Aide #118 provided Inspector #625 with a "Side Rail and Alternative Equipment Decision Tree" dated a specific date in July of 2015 that had been completed for resident #024's use of bed rails. The Restorative Care Aide identified that a new "Side Rail and Alternative Equipment Decision Tree" should be completed when residents' preferences change, residents change beds or residents' functional status changed. The Restorative Care Aide also indicated that resident #024 required a new "Side Rail and Alternative Equipment Decision Tree" to be completed when the resident moved into a specialized type of bed on a specific date in January of 2016, and the resident's preference for the use of bed rails may change as the specialised type of bed provided more room for the resident. The resident had been using the specialized type of bed with bed rails for 60 days without a current "Side Rail and Alternative Equipment Decision Tree" being completed. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #7: 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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

A Critical Incident System report was submitted in March of 2016 at 1717 hours, 65 hours after an incident of staff to resident neglect occurred. The report indicated that resident #028 had repeatedly asked PSW #119 for assistance and that PSW #119 did not respond to the resident's requests.

A review of the home's policy "Resident Non-Abuse – Ontario – LP-C-20-ON" revised September 2014, defined neglect as identified in Ontario Regulation 79/10 and listed examples as unreasonably ignoring a call for assistance and refusing to provide assistance to the bathroom when the resident requests or requires such assistance.

The policy also stated that any staff member or person, 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 Executive Director (ED) of the Home or, if unavailable, to the most senior

Supervisor on shift at that time. The person reporting the suspected abuse of neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately.

Inspector #625 reviewed the home's investigation file, which included staff interview responses, for the incident of neglect that occurred in March of 2016 at approximately and revealed that:
- on a specific date in March of 2016, PSW #120 overheard resident #028 repeatedly request assistance from PSW #119 who did not provide assistance to the resident;
- on that same date, PSW #120 spoke to RPN #115 about the witnessed incident;
- two days later, PSW #120 notified RPN #135 about incident;
- 48 hours after the incident, RPN #135 informed RN #121 of the incident; and
- 53 hours after the incident, RN #121 notified the Executive Director of the incident by email.

During an interview with Inspector #625 on March 9, 2016, the Executive Director stated that staff did not immediately report the neglect of resident #028 to the most senior Supervisor on shift at the time as required in the home's "Resident Non-Abuse" policy, but should have. [s. 20. (1)]

2. A Critical Incident System report was submitted in March of 2016, 49 hours after an incident identified in the report of improper or incompetent treatment of a resident that results in harm or risk of harm to a resident occurred. The report indicated that PSW #119 was providing care to resident #021. As PSW #119 was assisting the resident, the PSW hurt the resident.

A review of the home's policy "Resident Non-Abuse – Ontario – LP-C-20-ON" revised September 2014, defined physical abuse as identified in Ontario Regulation 79/10 and listed rough handling as an example.

A review by Inspector #625 of the home's investigation file, including staff interview responses, for the incident of physical abuse that occurred in March of 2016 revealed that:
- on a specific date in March of 2016, PSW #119 was rough with and hurt resident #021 while providing care to the resident. Resident #021 informed both PSW #119 and PSW #136 that they had been hurt at the time of the incident;
- the same day, PSW #119 informed RPN #135 that they had hurt resident #021 during the provision of care;

- the next day, resident #021 stated to PSW #120 that PSW #119 hurt the resident while providing care;
- the next day, PSW #120 notified RPN #135 about the incident;
- 30 hours after the incident, RPN #135 informed RN #121 of the incident; and
- 35 hours after the incident, RN #121 notified the Executive Director of the incident by email.

During an interview with Inspector #625 on March 9, 2016, the Executive Director stated that staff did not immediately report the physical abuse of resident #021 to the most senior Supervisor on shift at the time as required in the home's "Resident Non-Abuse" policy, but should have. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, without in any way restricting the generality of the duty provided for in section 19, 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct were given an opportunity to participate fully in the conferences.

An interview was conducted by Inspector #196 with the Resident Services Coordinator (RSC) as they placed a "Care Conference" document dated a specific date in March of 2016 into resident #005's chart. The RSC reported that the resident was capable of making care decisions, did not attend the conference as they were not invited and that the resident's family was invited but did not respond to the invitation. When questioned as to why the resident was not invited, the RSC reported that the resident had a temporary medical condition and, had stayed in bed, and that the annual care conferences were on a tight schedule and had to be held. The RSC confirmed that the pharmacist and the physician did not attend the conference. The RSC reported that the resident did not have any input into the discussion at the care conference and had not signed the area on the document that acknowledged the plan of care was reviewed and agreed upon by the resident. [s. 27. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with Inspector #577, resident #013 stated that they have a bath once a week and would prefer to have a bath twice a week.

A review of resident #013's care plan revealed that the resident requested a bath once a week.

During an interview, PSW #132 indicated that resident #013 had a bath once weekly, as per the resident's request.

During an interview with Associate DOC #102, they confirmed that resident #013 had requested a bath once weekly for quite a while and there was no process to re-evaluate the resident's choices.

During an interview with the Executive Director, they confirmed that there were residents who preferred to have a bath once weekly, and there was no process in place to confirm if a resident's choice had changed. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment was required.

During an interview with Inspector #577, resident #013 stated that they had chewing problems because of a specific physical condition.

During an interview with PSW #133, they stated that resident #013 does wear their upper dentures but does not wear their lower dentures as they are painful.

A review of resident #013's care plan by Inspector #577 revealed that resident #013 had upper and lower dentures and often refused to wear the lower dentures.

During an interview with Associate DOC #102, they stated that a dental hygienist attends the home and every resident is offered an annual dental assessment at their annual care conference.

During an interview with Inspector #577, the Resident Services Coordinator indicated that every resident is offered an annual dental assessment at their annual care conference. They confirmed that resident #013 refused to attend their last

annual care conference and an annual dental assessment was not offered to the resident. [s. 34. (1) (c)]

2. During an interview with Inspector #625 on March 7, 2016, resident #024 stated that they had removed their dentures as they were uncomfortable and would reinsert the dentures before the next meal so that they did not cause discomfort when not in use.

A review of the policy "Oral Assessment and Care - LTC-H-20" revised May 2013 indicated that residents and their Substitute Decision Makers or family will be provided with information about oral health professionals on admission or whenever required. Oral health professionals included dentists, denturists and dental hygienists.

A review of resident #024's Annual Care Conference sheet dated dated on a specific date in January of 2016 indicated that an annual dental check-up was not reviewed and it was noted that resident had dentures.

During an interview with the Acting DOC, they stated that dental assessments were offered during admission and annual care conferences. The Acting DOC indicated that the Resident Services Coordinator leads the care conferences and could identify if family was contacted after the care conference to discuss the findings.

During an interview with the Resident Services Coordinator, they stated that they had not contacted the resident's Substitute Decision Maker (SDM) to discuss the care conference with the SDM. They also indicated that nursing staff were not present at resident's care conference and had not provided the Resident Services Coordinator with any items to discuss at the care conference. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements in Ontario Regulation 79/10 s. 47 (2) or the requirements in s. 47 (3).

A review of Personal Support Worker (PSW) #119's employee file by Inspector #625 identified documents indicating that the PSW had obtained a diploma on a specific date in 2014 from a program other than the Personal Support Worker program, and was hired by the home in 2015.

A review by Inspector #625 of a professional regulatory body's website identified that PSW #119 did not have an active registration with the regulatory body and was not entitled to practice as a registered professional in that field.

A review of interview notes between the Executive Director (ED) and PSW #119 dated a specific date in March of 2016, identified that the ED questioned PSW #119 as to their qualifications to work as a PSW in long-term care. PSW #119 stated that they were not enrolled in school as they had completed their program, that they did not have a registered professional license and that they did not have a PSW diploma or certificate.

During interviews with Inspector #625 one day prior to and one day after the interviews between the ED and PSW #119, the ED stated that PSW #119 was employed as a PSW in the home, that they did not have a PSW certificate and that they were not currently enrolled in or attending school. The ED stated that PSW #119 was hired based on having a diploma from a program other than a PSW program, but they were not registered as a professional in that field. The ED confirmed that PSW #119 did not meet any of the qualification required of a PSW to work in long-term care, had been hired without being qualified and should not been hired. [s. 47. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, (a) has successfully completed a personal support worker program that meets the requirements in subsection (2), to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the falls prevention program provided for assessment and reassessment instruments.

A review of the home's written program "Fall Interventions Risk Management (FIRM) Program - LTC-E-60" last revised March 2014, indicated that reassessment of the resident would consist of the need for a falling star logo, which would be reassessed quarterly and annually. The policy also indicated that, for post-fall management, the nurse was to complete an immediate assessment of the resident, complete a progress note, initiate a neurological assessment and monitor the resident for 72 hours. For unwitnessed falls, a complete clinical assessment was to be completed and documented including shiftly vital signs for 72 hours.

During an interview with Inspector #577, the Acting DOC and Executive Director both confirmed that the home's written program "Fall Interventions Risk Management (FIRM) Program - LTC-E-60" last revised March 2014, did not identify the "Resident Post Fall Assessment Documentation" sheet that was currently used in the home as a post-fall assessment and re-assessment instrument, but indicated that the policy stated that post-fall documentation was to be completed in a progress note. [s. 48. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each program must, in addition to meeting the requirements set out in section 30, provides for assessment and reassessment instruments, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of resident #011's progress notes by Inspector #577 revealed that the resident had fallen on a specific date in November of 2015.

A review of resident #011's health records revealed that the resident did not have a post-fall assessment completed using a clinical instrument on the specific date of the fall in November of 2015.

During an interview with Inspector #577, the Associate DOC #102 indicated that the "Resident Post Fall Assessment Documentation" tool was the home's clinical instrument which was to be completed after every fall. They confirmed that a "Resident Post Fall Assessment Documentation" was not completed for resident #011 for the fall that occurred on a specific date in November of 2015.

During an interview with Inspector #577, the Associate DOC #104 and Acting DOC, both confirmed that the "Resident Post Fall Assessment Documentation" was the home's clinical tool and was required to be completed after every fall. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration were implemented.

Inspector #196 reviewed the health care records for resident #005 for information regarding an alteration in skin integrity.

On a specific date in October of 2015, resident #005 was identified to have an alteration in skin integrity on a specific body part as indicated on an "Initial Wound Assessment".

An interview was conducted on March 10, 2016 with the Registered Dietitian who confirmed that a quarterly nutrition assessment was completed for resident #005 on a specific date in December of 2015, as per the regular schedule. The Registered Dietitian reported that a referral for an assessment by the Dietitian was not received after the wound was identified on the specific date in October of 2015.

An interview was conducted with the Associate DOC #102 who reported that the incorrect form was completed on a specific date in November of 2015 for the referral to the Registered Dietitian and, as a result, an assessment by the Dietitian was not completed at the time of the altered skin integrity [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #196 reviewed an admission continence assessment dated a specific date in the summer of 2015, completed for resident #001 which identified the resident as continent of urine. The assessment did not reference bowel continence.

The "Resident/Family Questionnaire" completed by resident #001 and their family on a specific date in the summer of 2015, identified the resident as having an alteration of urinary elimination requiring the use of a containment product and noted an alteration in the resident's bowel elimination pattern.

An interview was conducted by Inspector #196 with resident #001, who reported they did experience an alteration in their bowel elimination pattern due to a specific medical treatment. They also reported that they were continent of urine and used the containment product because of an alteration in their bowel elimination pattern.

An interview was conducted on March 10, 2016 with PSW #134 who reported that resident #001 used a containment product, had the occasional alteration of urinary elimination and had an alteration in their bowel elimination pattern the very odd time. The PSW also reported that the resident rarely required assistance related to urinary and bowel elimination, including use of the containment product, since admission to the home.

The continence assessment instrument used by the home did not include the assessment of bowel function as was confirmed by Associate DOC #104. There were no further assessments of continence found for resident #001. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents’ Council advice related to concerns or recommendations.

A review by Inspector #577 of the Residents’ Council meeting minutes dated a specific date in November of 2015, identified a concern about missing clothing. The Executive Director became aware of this concern the following day, as they had signed the minutes on that day and did not respond in writing.

A review by Inspector #577 of the Residents’ Council meeting minutes dated a specific date in January of 2016, identified a concern about a disruptive person during meal times. The Executive Director became aware of this concern two days later, as they had signed the minutes on that day and did not respond in writing.

A review by Inspector #577 of the Residents’ Council meeting minutes dated a specific date in February of 2016, identified recommendations specific to "bingo buck" (money to be given as prizes at special bingos) and a request for more dancers to come in to entertain, such as square dancers and line dancers. The Executive Director became aware of these recommendations the following day, as they had signed the minutes on that day and did not respond in writing.

During an interview with the Recreation Services Manager #109, they confirmed that the Residents' Council did not receive a written response to their concerns and recommendations.

During an interview with the Executive Director, they confirmed that it was the home’s expectation that all concerns and recommendations made by the Residents' Council were responded to in writing within ten days, and that not all concerns or recommendations had been responded to in writing. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

A Critical Incident System report was submitted for an incident of resident to

resident abuse that occurred on a specific date in February of 2016. The report indicated that, during a recreation program, contractor #123 witnessed resident #025 touch resident #026 in a sexual nature.

The Long-Term Care Homes Act, 2007 defines the term "staff", in relation to a long-term care home, to mean persons who work at the home and includes persons working in the home persuant to a contract or agreement with the licensee, or persuant to a contract or agreement between the licensee and a third party.

A review of the home's "Resident Non-Abuse - Ontario - LP-C-20-ON" policy revised September 2014, indicated that all staff members and volunteers would be required to read the policy and sign the "Resident Non-Abuse Acknowledgment Form" upon hire, before commencing work. The policy identified staff and volunteer training, to be completed prior to performing responsibilities and annually thereafter, to include training on The Residents' Bill of Rights, the "Resident Non-Abuse National Policy" and "Resident Non-Abuse Acknowledgment Form", situations that may lead to abuse and neglect and how to avoid such situations and the duty to make mandatory reports of abuse and neglect. The policy stated that all staff and volunteers interacting with residents on a regular basis would be trained on procedures and interventions to assist and support residents who have been abused or neglected, or allegedly abused and neglected; and on how to deal with persons who have abused or neglected, or allegedly abused or neglected.

During an interview with Inspector #625 on March 10, 2016, the Executive Director (ED) stated that contractor #123 attended the home in a paid capacity two times per month, and as a volunteer two times per year, but had not receive training as required in the Long-Term Care Homes Act, 2007 sections 76 or 77, as required for staff and volunteers at the home, respectively. The ED stated that contractor #123 should have received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, but did not. [s. 76. (2) 3.]

2. The licensee has failed to ensure that staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

A review of the home's "Resident Non-Abuse - Ontario - LP-C-20-ON" policy

revised September 2014, indicated that all staff members and volunteers would be required to read the policy and sign the "Resident Non-Abuse Acknowledgment Form" upon hire, before commencing work. The policy identified staff and volunteer training, to be completed prior to performing responsibilities and annually thereafter, including training on the duty to make mandatory reports of abuse and neglect.

During an interview with Inspector #625 on March 10, 2016, the Executive Director (ED) confirmed that contractor #123 witnessed sexual abuse occur between residents #025 and #026 on a specific date in February of 2016, and notified RPN #113 following completion of the activity program. The ED stated that contractor #123 attended the home in a paid capacity two times per month, and as a volunteer two times per year, but had not receive training as required in the Long-Term Care Homes Act, 2007 sections 76 or 77, as required for staff and volunteers at the home, respectively. The ED confirmed that the training should have been provided to contractor #123, but was not. [s. 76. (2) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in: the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; and the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of maintenance services under clause 15(1)(c) of the Act, there were schedules and procedures in place for routine, preventive and remedial maintenance.

On March 1, 2016, Inspector #625 observed the grab bar in a resident's room to be loose and to have one screw coming out from the wall.

On March 2, 2016, Inspector #625 observed an electrical cover in a resident's room to be cracked and have a piece broken off.

On March 2, 2016, Inspector #625 observed wires above the heater in a resident's room not to be secured in place at one end.

During an interview with Inspector #625 on March 11, 2016, the Environmental Services (ES) Manager stated that there was no schedule in place for routine, preventative, and remedial maintenance in residents' rooms and that environmental audits would not be conducted in residents' rooms to identify any maintenance needs unless a resident permanently vacated the room. The ES Manager confirmed that scheduled environmental audits would not be conducted to ensure functionality and a state of good repair in residents' rooms if the residents resided in the room for a "long" duration of time. [s. 90. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

During a review by Inspector #577 of the Residents' Council meeting minutes, it was revealed that an anonymous complaint was received by the Executive Director on a specific date in February of 2016. The complaint outlined several concerns about food, resident beds not being made and wandering residents.

During an interview with the Executive Director, they confirmed that the complaints were investigated and resolved, but the complaint was not forwarded to the Director. They further stated that because the written complaint was anonymous, they did not realize it needed to be forwarded to the Director. [s. 22. (1)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs.

A review by Inspector #625 of a Physiotherapy Assessment completed on a specific date in May of 2015 for resident #022 stated that resident had physical health conditions and they were a high risk for falls. The assessment also stated that the resident would benefit from physiotherapy three to five times per week.

A review of a Physiotherapy Assessment completed on a specific date in August of 2015 for resident #022 stated that the resident had physical health conditions and continued to be a high risk for falls. This assessment stated that the resident would benefit from physiotherapy one to two times per week.

A review by Inspector #625 of resident #022's health care record identified a progress note entered by Physiotherapist #111 six days after the Physiotherapy Assessment was completed in August of 2015, that indicated that the resident had exhibited responsive behaviours during one physiotherapy session. After two minutes the staff member re-approached the resident who apologized and performed the exercise. Following this incident, as a result of the behaviour exhibited by the resident during the physiotherapy session, the resident was discharged from physiotherapy and the reason for the discharge was recorded as "agitated behaviours".

During an interview with Inspector #625 on March 11, 2016, Physiotherapist #111 stated that resident #022 was discharged from Physiotherapy as documented in the resident's health care record, because of the behaviours displayed by the resident as captured in the August 2015 progress note.

A review of the physiotherapy provider's "Achieva Health Education &Training" manual identified important approach considerations when working with residents demonstrating behaviours, including being aware of objects of opportunity, not to over-react and remember that verbally protective behaviour will not hurt staff physically and to work in pairs or request an assignment switch if required.The manual also identified that physiotherapy staff were to identify triggers to the episode and determine how to reduce the triggers in the future. [s. 59. (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 70. Dietary services
Every licensee of a long-term care home shall ensure that the dietary services component of the nutrition care and dietary services program includes,
(a) menu planning;
(b) food production;
(c) dining and snack service; and
(d) availability of supplies and equipment for food production and dining and snack service. O. Reg. 79/10, s. 70.

Findings/Faits saillants :

1. The licensee has failed to ensure that the dietary services component of the nutrition care and dietary services program included availability of supplies and equipment for food production and dining and snack service.

On March 10, 2016 at 1815 hours, Inspector #196 made observations of the main dining room. The Associate Director of Care (DOC) #104 was present in the dining room conducting an audit of the dining service. The residents' tables did not have table coverings in place, residents were served entrees on styrofoam plates and saucers were not used with the coffee cups.

During an interview conducted by Inspector #196 on March 11, 2016, the ED reported that, unknown to them, disposable plates were used for resident meals when the kitchen was short staffed. The ED confirmed that this was not conducive to pleasurable dining for the residents of the home. [s. 70. (d)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that, when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A review by Inspector #625 of the policy "PRN Medications - Administration and Documentation" revised November 2015 identified that pro re nata (PRN or as needed) medication would be appropriately ordered, administered and evaluated for effectiveness.

A review by Inspector #625 of resident #024's medication administration history identified that a PRN analgesic was administered on specific date in March of 2016. A progress note identified that the medication was given, for complaints of pain, by RPN #113. The medication administration history identified that, on the day after the PRN analgesic was administered, the effectiveness of the analgesic was not documented, but was marked as "unknown" by RPN #114.

During interviews with Inspector #625 on March 8, 2016, the Acting DOC and Associate DOC #104 stated that it was the expectation that staff document the effectiveness of PRN pain medication. During an interview with the Associate DOC #104 on March 9, 2016, they acknowledged that the effectiveness of the PRN analgesic administered on the specific date in March of 2016 was not documented. [s. 134. (a)]

Issued on this 5 day of August 2016 (A1)

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KATHERINE BARCA (625) - (A1)

Inspection No. / No de l'inspection : 2016_433625_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005653-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 05, 2016;(A1)

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

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

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

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)

Pursuant to / Aux termes de :

LTCHA, 2007, 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or

transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (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 ensure that the following rights of residents are fully respected and promoted: 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; and the right to be protected from abuse.

The licensee is ordered to ensure that any resident that is ceasing to engage in a specific activity has timely access to products to assist is ceasing the activity. If specific products are not immediately available to the resident, the home shall consider alternative products or strategies to minimize the risk to the resident of engaging in the activity until appropriate products can be obtained.

The licensee is ordered to review the Residents' Bill of Rights and the home's zero tolerance of abuse and neglect policy with the family member of resident #030, RPN #125 and Housekeeper #129.

The licensee is ordered to intermittently monitor the family member of resident #030, RPN #125 and Housekeeper #129, to ensure they demonstrate an understanding of and compliance with the Residents' Bill of Rights and the home's zero tolerance of abuse and neglect policy, for a duration of time to be determined by licensee to be adequate to ensure compliance is demonstrated.

Grounds / Motifs :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

On a specific date in February of 2016, Inspector #625 observed resident #031 return from an activity outside of the home.

On a specific date in March of 2016, resident #031 informed Inspector #625 that they were no longer permitted to engage in the activity by the home and had not engaged in the activity since the previous day. Resident #031 stated they were upset because they could no longer engage in the activity and asked Inspector #625 to speak with the home's management to determine why they could not longer engage in the activity, as the resident did not know why they were no longer permitted to engage in the activity by the home.

A review of resident #031's health care record by Inspector #625 was conducted.

During an interview with Inspector #625 in March of 2016, the Executive Director (ED) confirmed that resident #031 was no longer permitted to engage in the activity by the home due to safety concerns. The ED stated that the resident engaged in the activity in excess of 20 times per day and that there had been a delay in obtaining and using an associated product to the activity as approval was required for the cost, and that the resident had not been permitted to engage in the activity by the home while waiting for the product to be in place. (625)

2. During an interview with Inspector #577 on a specific date in March of 2016, resident #012 stated that Housekeeper #129 yelled at them when they were looking for an item in their roommate's drawer weeks prior. Seven days after the interview, resident #012 further revealed that they were still upset.

A review of resident #012's progress notes dated a specific date in February of 2016 by Inspector #577, identified that the resident was observed by a staff member going into their roommate's dresser drawer. The progress note stated that resident #012 was redirected, that education was provided to the resident regarding personal belongings and personal space, and that the resident was asked and reminded to not access other residents' belongings. The progress note also stated that resident #012 was upset.

During an interview with the Inspector #577, the Acting DOC stated that they had spoken with resident #012, that the resident was upset with Housekeeper #129 for accusing them of stealing an item. The Acting DOC indicated that, during their interview with Housekeeper #129, the Housekeeper denied accusing the resident of stealing and told the resident that they shouldn't be going into other residents' belongings. (625)

3. The licensee failed to ensure that the rights of residents were fully respected and promoted, including the right to be protected from abuse.

A Critical Incident System report was submitted to the Director for an incident of visitor to resident abuse that occurred in January of 2016. The report indicated that resident #017 was moving towards resident #030 and their visiting family member. Resident #030's family member mocked resident #017's words and then moved resident #017 away from resident #030.

The Critical Incident System report was amended the next day to indicate that the ED had provided resident #030's family member with a letter that indicated the family member had violated the home's "Resident Non-Abuse" policy and the Residents' Bill of Rights, both of which had been provided to the family member upon the admission of resident #030 to the home. The report also indicated that resident #030's family member confirmed to the ED that the incident had occurred and that what they stated

to resident #017 had been wrong.

Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review by Inspector #625 of the home's policy "Resident Non-Abuse – Ontario - LPC-20-ON" last revised September 2014, identified the definition of emotional abuse as that defined in Ontario Regulation 79/10 and provided examples including humiliation, intimidation, sarcasm, mocking and ridiculing.

A review of a note from the ED signed in January of 2016 revealed that resident #017 was moving toward resident #030 while vocalizing prior to resident #030's family member responding as detailed in the Critical Incident System report.

A review of a letter dated January of 2016 from the ED to resident #030's family member stated that the family member mocked a resident and moved the resident away from the family member's direct area. The letter indicated that the family member's actions were in direct violation of the Residents' Bill of Rights and the home's "Resident Non-Abuse" policy, both of which the family member was aware of when admitting resident #030 to the home, and that the behaviour was classified as emotional abuse
according to the LTC Homes Act, 2007.

During an interview with Inspector #625 on March 10, 2016, the ED confirmed the details in the letter dated January of 2016, including that the family member emotionally abused resident #017. (625)

4. A Critical Incident System report was submitted to the Director in February of 2016, outlining an incident of abuse towards resident #001 by RPN #125.

Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

The home's policy "Resident Non-Abuse – Ontario - LP-C-20-ON" last revised September 2014, identified the definition of emotional abuse as that defined in Ontario Regulation 79/10 and provided examples including humiliation, intimidation, sarcasm, mocking, ridiculing, name calling, threatening or instilling fear.

A review of the home's investigation file by Inspector #196 determined that RPN #125 had psychologically abused resident #001, referred to the resident in a derogatory manner and stated that if the resident wasn't happy with the care then they should go somewhere else.

The scope of non-compliance with the Resident's Bill of Rights s. 3. (1) 1 was isolated to two individual residents. The severity was determined to be actual harm. There was previous related non-compliance issued under s. 3. (1) 1: under inspection 2015_380593_0020 conducted July 27, 2015 when a Written Notification was issued; under inspection 2015_269597_0003 conducted March 9, 2015 when a Voluntary Plan of Correction was issued; under inspection 2013_246196_0021 conducted December 10, 2013 when a Voluntary Plan of Correction was issued; and under inspection 2013_224122_0001 conducted May 8, 2013 when a Compliance Order was served on June 5, 2013.

The scope of non-compliance with the Resident's Bill of Rights s. 3. (1) 2 was isolated to two individual residents. The severity was determined to be actual harm. There was no previous related non-compliance issued under s. 3. (1) 2. (196)

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

Jul 25, 2016

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

Order # / Ordre no : 002

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

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 :

The licensee is hereby ordered to complete a thorough review of each resident's plan of care, consulting with each resident, substitute decision-maker and multidisciplinary staff, as appropriate, ensuring that the documented care is reviewed and revised, as required. The plan of care shall set out the planned care for each resident and provide clear directions to staff and others who provide direct care to the resident.

The licensee is ordered to conduct an audit to ensure that all current orders made by the Physician, Registered Nurse (EC), Registered Dietitian and all other health care providers with the authority to order medications and/or treatments for residents, provide clear directions to staff and others who provide direct care to residents, and are accurately reflected in the residents' Medication Administration Records, Treatment Administration Records, care plans and all components of each resident's plan of care.

The home's leadership team will review and approve the content of each resident's plan of care, ensuring the components are current, complement and are consistent with each other.

The home shall put into place a system to conduct routinely scheduled audits of residents' plans of care to ensure they are compliant with s. 6. (1). The plan of care audit sample shall ensure representation of residents from a variety of home areas and include residents requiring interventions related to falls prevention and management, skin and wound care, continence care and bowel management, pain management and responsive behaviours. The audits are to be conducted by registered staff or a member of the home's leadership team. Each audit must be reviewed by a member of the home's leadership team to verify accuracy of the audit, to document actions taken to address specific deficient findings and to document system level changes made in response to the findings.

Grounds / Motifs :

1. (a) The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During an interview on March 7, 2016 with Inspector #196, resident #002 and their spouse reported that, on a daily basis, a specific component of oral care was

provided in the evening and in the morning. They also reported that a second specific component of oral care was not done daily.

The current care plan was reviewed by Inspector #196 and, under the focus of oral hygiene, it was indicated that the resident required staff assistance with oral care as evidenced by the resident's inability to complete the task independently due to specific health conditions. The interventions did not include the second specific component of oral care.

During an interview with Inspector #196 on March 9, 2016, the Associate DOC #104 confirmed that the care plan should have had the second specific component of oral care to be provided twice daily noted in the care plan, in addition to the first specific component of oral care.

(b) A review of resident #024's current care plan related to oral hygiene by Inspector #625 indicated that the resident required assistance with mouth care by staff, that staff were to provide a specific component of oral care if indicated by a specific criteria, that the resident had a second specific component of an oral care routine to be completed overnight and in the morning, and identified communication techniques to use.

A review of the home's policy "Oral Assessment and Care - LTC-H-20" last revised May 2013, by Inspector #625, indicated that residents would receive or be cued to perform oral care at least twice daily and that each resident's individualized oral care needs would be documented in their care plan.

During an interview with Inspector #625, PSW #116 stated that they were familiar with resident #024's oral care routine. PSW #116 stated that the resident had specific oral care provided overnight, in the morning and at night, that they resident would notify staff of preferences related to the oral care as their as their choice differed nightly. The PSW stated that, if a staff member who was unfamiliar with resident #024 reviewed the care plan, they would not know to provide the resident with a the second specific component of oral care regularly, and would only do so if the specific criteria was identified.

During an interview with Inspector #625, PSW #112 reviewed resident #024's care plan related to oral hygiene. When asked how the PSW would provide oral care to the resident based on the care plan, they stated that, as they did not work during the

day shift, they would not know how to provide oral care to the resident in the morning from what was identified in the care plan. (625)

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During a review of resident #021's current care plan by Inspector #625, an intervention was identified indicating that a safety device was in use to prevent the resident from falling.

A review of resident #021's health care record identified a progress note dated December of 2015, entered by RPN #117, that stated that resident #021's family had requested the safety device be removed, and that a message was left for the Restorative Care Aide (RCA) with this information. A second progress note dated December of 2015 was entered by RCA #118 that stated the safety device was removed as per the family's request.

During an interview with Inspector #625 on March 8, 2016, the Acting DOC stated resident #021's current care plan listed the use of the safety device for the resident to prevent the resident from falling. The Acting DOC confirmed with RCA #118 that resident #021's family had requested the safety device be removed and that the RCA had removed the device at that time, from the the area where it had been in use.

The Acting DOC accompanied Inspector #625 to the resident's room and confirmed that the safety device was not present in the area where it had been in use, although the use of the safety device was still identified in resident #021's current care plan. (625)

3. A review of resident #022's health care record by Inspector #625 identified a progress note dated November of 2015 indicating altered skin integrity on a specific area was resolved.

A review of resident #022's TAR for March 2016 listed a treatment for altered skin integrity on a second area, but reflected that the treatment was no longer required after a specific date in March of 2016.

A review of resident #022's current care plan continued to indicate that the resident had altered skin integrity on both areas.

During an interview with Inspector #625 in March of 2016, Associate DOC #102 confirmed that resident #022's altered skin integrity of the specific area was resolved in November of 2015 as the progress note stated, but that the care plan was not updated at the time as it should have been. The Associate DOC #102 also stated that resident #022's altered skin integrity of the second area had resolved on a specific date in March of 2016 as was reflected on the March 2016 TAR, but that the current care plan had not been updated as it should have been. (625)

4. A review of resident #024's health care record by Inspector #625 included:
- two different entries for a clinical procedure listed on the January, February and March 2016 Medication Administration Records (MARs). The first entry indicated that a specific clinical procedure (including the size of the equipment) was to be completed, and the second entry instructed staff to adjust the size of the equipment if needed to prevent an undesirable outcome. The first entry also instructed staff to complete the procedure each month on a specific date as needed, and the second entry instructed staff to complete the procedure monthly, on no identified date, as needed;

- a "Physician's Order Review" dated February of 2016, that ordered a clinical procedure be performed when needed. The order did not specify the information listed on the MARs such as if the procedure was to occur each month on a specific date as needed, if the procedure was to occur monthly as needed on no specific date, if staff were to use a specific size of equipment, or if staff were to adjust the equipment size if needed to prevent an undesirable outcome; and

- a care plan related to the use of clinical equipment, last reviewed in February of 2016 that directed staff to the Treatment Administration Record (TAR) for clinical equipment information, yet the TARs for November of 2015, December of 2015, January of 2016 and February of 2016, did not contain this information.

During an interview with Inspector #625 on March 7, 2016, RPN #115 stated that resident #024's clinical procedure was completed as needed.

During an interview with Inspector #625 on March 7, 2016, the Associate DOC #104 reviewed the “Physician's Order Review” dated February of 2016 that indicated resident #024's clinical procedure was to be completed when needed. They also reviewed the current MAR that listed two different clinical procedure instructions. The Associate DOC #104 stated there were discrepancies in the information related to clinical procedure in resident #024’s health care record.

During an interview with Acting DOC, they stated that the physician's order and the MAR for resident #024 did not provide clear direction to the staff on how to complete the clinical procedure for the resident. (625)

5. On March 3 and March 7, 2016, Inspector #625 observed resident #024 in bed with two partial bed rails in the raised position.

A review of resident #024's current care plan did not indicate that bed rails were in use.

A review of the most current "Side Rail and Alternative Equipment Decision Tree - LTC-10-05-ON" completed in July of 2015 by Restorative Care Aid #118 indicated that resident #024 used two quarter bed rails in a specific type of bed.

During an interview with Inspector #625 on March 7, 2016, PSW #112 stated that the resident used bed rails. PSW #112 could not locate the use of bed side rails on the resident's Kardex. PSW #112 located the use of bed rails for resident #024 listed as a task for PSWs to sign each shift, to indicate that the bed rails were in place.

During an interview with Inspector #625 on March 8, 2016, Restorative Care Aid #118 confirmed that resident #024 requested the use of bed side rails prior to receiving a specialized bed in January of 2016. Restorative Care Aid #118 could not confirm if resident #024 continued to request the use of bed side rails in the new specialized bed and stated that a new "Side Rail and Alternative Equipment Decision Tree - LTC-10-05- ON" form should have been completed when the resident changed beds but was not done.

During an interview with Inspector #625, the Associate DOC #102 verified that the use of bed rails was not listed on resident #024's Kardex or care plan, even though they were in use.

During interviews with the Acting DOC on March 8, 2016, they confirmed that the use of bed rails for resident #024 had been included as a task for PSWs to complete, but not been listed in the resident's care plan or on the Kardex as it should have been.

The scope of non-compliance with s. 6. (1), Plan of Care, was isolated to two residents. The severity as determined to be the potential for actual harm to occur. There was previous related non-compliance issued under s. 6. (1): under inspection 2015_380593_0020 conducted July 27, 2015 when a Director's Referral was issued and a Compliance Order was served on September 11, 2015; under inspection 2015_269597_0003 conducted March 9, 2015 when a Compliance Order was served

on May 22, 2015; under inspection 2014_269597_0008 conducted December 3, 2014 when a Compliance Order was served on March 5, 2015; under inspection 2014_304133_0002 conducted January 29, 2014 when a Voluntary Plan of Correction was issued; under inspection 2013_217137_0056 conducted December 16, 2013 when a Compliance Order was served January 23, 2014; under inspection 2013_224122_0004 conducted June 12, 2013 when a Compliance Order was served on July 8, 2013; and under inspection 2013_204133_0015 conducted June 11, 2013 when a Voluntary Plan of Correction was issued. (625)

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

Aug 22, 2016

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee is hereby ordered to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee is ordered to:
a) Review the "Halsall Draft Property Condition Assessment" and identify any outstanding items requiring action by the home. Take action to address the items identified in the assessment including, but not limited to, any work required to ensure that cast iron fittings and drains are in a good state of repair, any work required to ensure the exhaust fan is operational and maintained as such, further investigation of the damaged joist and any repair required to ensure the structural integrity of the area.

b) Ensure there are schedules and procedures in place for routine, preventative and remedial maintenance to address the items identified in the "Halsall Draft Property Condition Assessment" and any applicable items located in the home's crawl space.

c) Ensure that an audit is conducted by a member of the home's Maintenance staff of all residents' bedrooms, washrooms, shower rooms and tub rooms. The audit shall assess all grab bars to ensure that they are properly and securely installed, and are maintained and kept free of corrosion and cracks. Any deficiencies shall be identified and addressed to ensure the safe condition and good state of repair of the grab bars.

d) Develop an auditing schedule for resident bedrooms, washrooms, shower rooms and tub rooms to ensure that the grab bars are properly and securely installed, and are maintained and kept free of corrosion and cracks. Any deficiencies shall be identified and addressed to ensure the safe condition and good state of repair of the grab bars.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On a specific day in January of 2016, an incident occurred which resulted in a sewer back up across the home's crawl space. The invoice from the service provider indicated that there was a compromised cast iron fitting and a drain line that had

rotted open.

During an interview with Inspector #196 on March 6, 2016, the Environmental Services (ES) Supervisor stated that a "bad odour" had occurred the day after the sewage leak which could be smelled in the elevators, a hallway and specific rooms on the main floor. A service provider attempted to neutralize the air over a period of three weeks but the odour returned after a couple of days requiring retreatments. A second service provider was contacted and determined that an exhaust fan located in the crawl space, which was required to run continuously, was not operational. The ES Supervisor stated that they did not know how long the fan had not been operational but, since being employed in the home for over three and a half years, they had no knowledge of the fan, or of any maintenance performed on the fan. The ES Supervisor stated that preventative maintenance had not been conducted on the crawl space in the past.

During an interview regarding the maintenance of plumbing and drains in the crawl space conducted by Inspector #196 on March 11, 2016, the Executive Director (ED) produced a document titled "Halsall Draft Property Condition Assessment" for the home dated November of 2011. Within the document, it identified that "The crawl space has an exposed dirt floor. The exposed pipes and structure have significant surface corrosion, likely due to vapour transfer from the soil. We recommend that the dirt floor be covered with heavy duty polyethylene to minimize vapour transfer. We have included a budget to repair the crawl space".

Further review of the "Halsall Draft Property Condition Assessment" identified that "In June 2009, we noted that one of the top chords in the crawl space has a kink and this would be considered a structural failure of the joist(s) at this location which can translate into sagging or cracking of the supported floor around this location. We were not able to visually confirm during our site visit if this joist was repaired but according to the ESM, this structural failure has not been addressed. We recommend further investigation of the damaged joist. We have also included a preliminary repair allowance".

During the interview with Inspector #196 on March 11, 2016, the ED reported, after consulting with the licensee, that the structural joist failure had not been repaired in 2012, that funds had been budgeted to investigate the concerns in the crawl space in 2013, but that no further investigative work was done in the crawl space, and that the recommendations identified in the "Halsall Draft Property Condition Assessment" had

not been implemented. The ED confirmed that the crawl space had not been inspected since the assessment was completed in 2011. (196)

2. On March 1, 2016 Inspector #625 observed the grab bar in resident #023's washroom to be loose and to have one screw coming out from the wall.

A review of resident #023's care plan last reviewed in February of 2016, identified that the resident required the use of the grab bar for safety and mobility.

During an interview with Inspector #625 on March 11, 2016, PSW #110 viewed the grab bar in resident #023's washroom, stated it was loose, and proceeded to move the grab bar approximately 10 cm from side to side. PSW #110 identified a crack in the drywall and stated that it had occurred as the result of the pressure of the grab bar when being used.

During an interview with Inspector #625 on March 11, 2016, the Environmental Services (ES) Manager stated that home's staff were required to fill out a "Physical Plant Service Requisition" to notify the Maintenance Department of any needed repairs and that there were no outstanding "Physical Plan Service Requisition" forms related to grab bars at that time.

The ES Manager and Inspector #625 attended resident #023's washroom and assessed the grab bar. The ES Manager stated that the grab bar was loose and coming out from the drywall, that the drywall was cracking as a result of the grab bar not being secured, and that a plate may need to be installed behind the grab bar to better secure it.

The scope of non-compliance with s. 15. (2) was widespread, demonstrating a systemic failure that had the potential to affect a large number of residents in the home. The severity was determined to be the potential for actual harm to occur. There was previous related non-compliance issued under inspection 2015_401616_0022 conducted on November 25, 2015 when a Written Notification was issued; and under inspection 2013_304133_0031 conducted November 6, 2013 when a Compliance Order was served on March 3, 2014. (625)

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

Aug 22, 2016

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)

Pursuant to / Aux termes de :

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 :

The licensee is hereby ordered to ensure that all residents are protected from abuse by anyone and to ensure that residents are not neglected by the licensee or staff.

The licensee is ordered to:
a) Ensure that all direct care staff (as defined in the Long-Term Care Homes Act, 2007) receive training on:
(i) abuse recognition and prevention, including the practical applications of training material and a review of resident abuse scenarios that have occurred in the home in 2015 and 2016; and
(ii) the home's current zero tolerance of abuse and neglect policies including, but not limited to, types of abuse, definitions of abuse and neglect, examples of abuse and neglect, internal and external reporting requirements and immediate interventions to occur following allegations or suspicions of resident abuse.

b) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of abuse recognition and prevention and the home's written polices to promote zero tolerance of abuse and neglect of residents.

c) Maintain records of the training provided including, but not limited to, dates,
times, attendees, trainers, materials taught and staff post-training evaluations.

d) Conduct an audit of the qualifications of all personal support workers currently employed in the home to ensure they meet the requirements identified in Ontario Regulation 79/10 s. 47. Take action to address any staff members who do not meet the qualifications required.

e) Ensure that all future personal support workers hired to work in the home meet the requirements identified in Ontario Regulation 79/10 s. 47.

f) Develop and implement a system to monitor compliance with the home's abuse and neglect policies which includes:
(i) ongoing monitoring, by the home's management team, of the provision of resident care and services and;
(ii) ongoing monitoring, by the home's management team, of interactions between residents and others; and
(iii) maintaining records of monitoring completed by the home's management team including, but not limited to, dates, times, durations, locations, observations and any actions taken, related to resident abuse and neglect, as a result of the monitoring.

g) Review the plan of care for resident #015 with a multidisciplinary team to determine if the interventions are effective and are are being consistently implemented by staff. Identify any challenges with implementation and introduce solutions to address the challenges.

h) Ensure that all internal and external consultants, supports and strategies have been utilized for resident #015, as appropriate, with the consent of the resident's substitute decision-maker. These shall include, but are not limited to, referrals to external consultants and resources; involving the resident's family, the home's multidisciplinary team and volunteers; assessing the population of residents residing in the the same home area as resident #015.

Grounds / Motifs :

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

A Critical Incident System report was submitted for an incident of resident to resident abuse that occurred on February 23, 2016. The report indicated that, during a recreation program, contractor #123 witnessed resident #025 touch resident #026 in a sexual nature. The report stated that contractor #123 did not intervene when witnessing this interaction.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a
resident by a person other than a licensee or staff member.

The Long-Term Care Homes Act, 2007 defines the term "staff", in relation to a long-term care home, to mean persons who work at the home and includes persons working in the home persuant to a contract or agreement with the licensee, or persuant to a contract or agreement between the licensee and a third party.

A review by Inspector #625 of the home's "Resident Non-Abuse – Ontario – LP-C-20-ON" policy last revised September 2014, identified sexual abuse as defined in Ontario Regulation 79/10 and provided examples including unwanted touching or molestation that is sexual in nature. The policy also indicated that all staff members and volunteers would be required to read the "Resident Non-Abuse - Ontario" policy and sign the "Resident Non-Abuse Acknowledgment Form" upon hire, before commencing work.

The policy also identified staff and volunteer training was to be completed prior to performing responsibilities and annually thereafter, and was to include training on The Residents' Bill of Rights, the "Resident Non-Abuse National Policy", the "Resident Non-Abuse Acknowledgment Form", situations that may lead to abuse and neglect, how to avoid such situations and the duty to make mandatory reports of abuse and neglect. The policy stated that all staff and volunteers interacting with resident on a regular basis were to be trained on procedures and interventions to assist and support residents who have been abused or neglected, or allegedly

abused and neglected and to deal with persons who have abused or neglected, or allegedly abused or neglected.

A review by Inspector #625 of the home's investigation file for the incident of sexual abuse that occurred in February of 2016, included a statement from contractor #123 that described the touch of a sexual nature of resident #025 to resident #026.

The investigation file also contained an email from the home's Executive Director (ED) describing an incident with resident #025 that occurred immediately prior the incident with resident #026.

During an interview with Inspector #625 on March 10, 2016, the Executive Director (ED) stated that, in February of 2016, resident #025 exhibited sexually inappropriate behaviour. The ED confirmed that contractor #123 witnessed the sexual abuse occur between residents #025 and #026, but did not notify RPN #113 of the incident until the program was completed.

The ED also stated that contractor #123 attended the home in a paid capacity two times per month, and as a volunteer two times per year, but had not receive training as required in the Long-Term Care Homes Act, 2007 sections 76 or 77, as required for staff and volunteers at the home, respectively. The ED also stated that contractor #123 had not received training on the Residents' Bill of Rights or the home's policy to promote zero tolerance of abuse and neglect of residents. The ED confirmed that the training should have been provided to contractor #123 but was not. (625)

2. A Critical Incident System (CIS) report was submitted in March of 2016 for an incident of staff to resident neglect that occurred three days prior. The report indicated that resident #028 had repeatedly asked Personal Support Worker (PSW) #119 for assistance with care and that PSW #119 did not respond to the resident's requests. PSW #120 heard the resident's unanswered requests for assistance and later provided assistance to resident #028, after completing care with another resident.

A second Critical Incident System report was submitted for an incident identified in the report as improper or incompetent treatment of a resident that results in harm or risk of harm to a resident that occurred one day after the incident detailed in the first

identified CIS report. The report indicated that the same employee identified in the first CIS report, PSW #119, was providing care to resident #021. As PSW #119 was assisting the resident, the PSW hurt the resident.

Ontario Regulation 79/10 defines neglect as the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The regulation defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain and states that physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

A review of the home's policy "Resident Non-Abuse - Ontario - LP-C-20-ON" last revised September 2014, defined neglect as identified in Ontario Regulation 79/10 and listed examples as unreasonably ignoring a call for assistance and refusing to provide assistance to the bathroom when the resident requests or requires such assistance. The policy defined physical abuse as identified in Ontario Regulation 79/10 and listed rough handling as an example.

A review by Inspector #625 of the investigation file for the incident of neglect that occurred in March of 2016 included documents that identified that resident #028 called out repeatedly, with increasing volume, that they needed assistance, and that PSW #119 did not respond to the resident's requests for assistance.

A review by Inspector #625 of the investigation file for the incident of physical abuse that occurred in March of 2016 included documents that identified that resident #021 had stated that PSW #119 was rough when assisting the resident with a specific aspect of the resident's care, and that PSW #119 had hurt the resident while providing care to them. The resident was also documented as saying that there had been previous incidents with PSW #119 that the resident did not report, the resident did not want PSW #119 to provide specific care to them in the future, and that the resident thought that PSW #119 was not patient enough to provide gentle care.

A review of the home's policy "Resident Non-Abuse – Ontario – LP-C-20-ON" revised September 2014, identified 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

Executive Director (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. The policy also identified that if a staff member was alleged, suspected or witnessed to have abused and/or neglected a resident, the staff member would be immediately suspended from
their duties and required to leave the premises pending investigation.

A review by Inspector #625 of the investigation files for the first Critical Incident System report, related to staff to resident neglect, and second report, related to staff to resident physical abuse, identified that, in March of 2015, PSW #120 witnessed the neglect of resident #028 by PSW #119 and did not notify the Executive Director or the most senior Supervisor on shift at that time. PSW #119 continued to attend work and, one day following the first incident of abuse, the PSW physically abused resident #021. RN #121, the most senior Supervisor on shift at the time, was notified 48 hours after the incident of neglect and 30 hours after the incident of physical abuse had occurred. The Executive Director was notified by email 53 hours after the incident of neglect and 35 hours after the incident of physical abuse had occurred.

A review by Inspector #625 of PSW #119's employee file revealed documents indicating that the PSW was hired by the home in 2015; PSW #119 did not have a diploma from a Personal Support Worker program; that PSW #119 had a diploma from another program, but was not a registered member of that program's profession; and that PSW #119 had been issued discipline for improper care of a resident that occurred in February of 2016.

During interviews with Inspector #625 on March 9, 2016, the Executive Director (ED) stated that staff did not report the first incident of resident neglect that occurred in March of 2016 immediately to the ED as was required, resulting in the ED not being notified, and the employee continuing to attend work the following day, when the incident of physical abuse occurred. The ED also stated that PSW #119 did not meet the qualifications for Personal Support Workers listed in Ontario Regulation 79/10 section 47. The ED confirmed that PSW #119 was hired into a personal support worker position for which they were not qualified. The ED also stated that, had PSW #119 not been hired, the neglect of resident #028 and the physical abuse of resident #021 on two separate dates in March of 2016 would not have occurred. (625)

3. A Critical Incident System report was submitted to the Director in relation to reported abuse by resident #015 towards resident #017 in February of 2016. The report specifically indicated that resident #015 attempted to sexually abuse resident #017.

Ontario Regulation 79/10 defines sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of the home's policy "Resident Non-Abuse - Ontario - LP-C-20-ON" last revised September 2014, defined sexual abuse as indicated in Ontario Regulation 79/10 and listed examples as unwanted touching or molestation that is sexual in nature.

A review of resident #015's progress notes by Inspector #577 identified three incidents of inappropriate sexual behaviours exhibited towards residents and four incidents of inappropriate sexual beahviours exhibited towards staff, from 2014 to 2016.

A review of resident #015's care plan found that the resident had responsive behaviours as evidenced by inappropriate sexual behaviour exhibited towards staff and other residents. Interventions were listed in the care plan.

A record review of resident #015's chart revealed that the resident was assessed by an outside agency in 2012, for inappropriate sexual behaviours made towards staff. The resident was discharged from the program in the summer of 2012. In 2013, the resident was referred again for sexual abuse of residents on a daily basis, and attempting to exhibit sexually inappropriate behaviours to visitors and staff. In winter of 2014, the resident was discharged from the program. During the summer of 2015, a consultation by a psychiatrist was done and determined that resident was no longer causing significant concerns and the outside agency was no longer involved.

A review of resident #015’s chart found “Sexually Inappropriate Behaviour Tracking Sheet" forms were implemented for 14 days in February of 2016 and again for two days in February of 2016 and 13 days in March of 2016, to closely monitor the

resident's behaviour.

On March 10, 2016 Inspector #577 observed resident #017 enter the TV lounge and seat themself beside resident #015 on two occasions, which left the residents unsupervised by home's staff for one to two minutes each time.

During an interview with Inspector #577, PSW #134 and RPN# 131 stated that resident #015 stayed in the TV lounge area and was supervised during a specific activity, and that these interventions were in place to keep resident #015 away from other specific residents.

During an interview with the Associate DOC #104, they confirmed that resident #015 stayed in their room, was always was supervised during a specific activity, could sit in the TV lounge when specific residents were not in the area, and that staff were to know resident #015's whereabouts at all times.

During an interview with the Executive Director (ED), they confirmed that it was the expectation of the home that all residents be protected from abuse and the home failed to protect resident #017 from abuse by resident #015. The ED further confirmed that staff should be monitoring and checking the whereabouts of resident #015 at all times.

The scope of non-compliance with s. 19 (1), Duty to protect, demonstrated a pattern of occurrence. The severity was determined to be actual harm. There was previous related non-compliance issued under under inspection 2015_401616_0020 conducted November 25, 2015 when a compliance order was served on January 7, 2016; under inspection 2015_380593_0020 conducted July 27, 2015 when a Director's Referral was issued and a compliance order was served on September 17, 2015; under inspection 2015_269597_0003 conducted on March 9, 2015 when a compliance order was served on May 22, 2015. (577)

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

Sep 30, 2016(A1)

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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 5 day of August 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHERINE BARCA - (A1)

Service Area Office /
Bureau régional de services : Sudbury