Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2015;	2015_293554_0003 (A1)	O-0001383	Follow up

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

KELLY BURNS (554) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

During a discussion with the Administrator of the home, it was determined that the licensee will not be able to meet the compliance due date of September 25, 2015, specific to LTCHA, 2007, s. 19 – Duty to Protect. Compliance Order (CO) #001 – issued during Inspection #2015_293554_0003.

An extension to the compliance due date was discussed, by the Administrator and Inspector; approval has been granted by the Ministry of Health and Long-Term Care.

The licensee must be in compliance with CO#001, LTCHA, 2007, s. 19, by October 26, 2015.

Issued on this 10 day of September 2015 (A1)

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

Original report signed by the inspector.

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KELLY BURNS (554) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 04-06 and February 09-14, 2015

During this Follow Up inspection, Intake #O-001383-14 was inspected, along with concurrent intakes #O-001507-15, O-001569-15, O-001601-15, O-001607-15, and O-001636-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Dietary Manager, Environmental Services Manager, Manager of Resident and Family Services, Office Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Registered Dietitian, Dietary Aide(s), Housekeeping Staff, Maintenance Worker, External Contracted Services, Residents and Families

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dignity, Choice and Privacy

Hospitalization and Change in Condition

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

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

9 WN(s)
2 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

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

The licensee failed to comply with LTCHA, 2007, s. 19 (1), by ensuring Resident #02 and Resident #06 was protected from abuse by anyone.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Related to Intake #O-001607-15 and Intake #O-001636-15, for Resident #06:

A Critical Incident Report(CIR) was submitted, by the Director of Care, for an incident of resident to resident sexual abuse, the incident was said to have occurred on a specific date.

The CIR submitted, by the DOC, provides explicit details of the incident of resident to resident sexual abuse which was said to have occurred between Resident #05 and Resident #06, on a specific date.

According to Resident #06's clinical health record, resident has a cognition impairment. Director of Care indicated Resident #06 is unable to give consent. Resident is dependent on staff for all activities of daily living.

Progress notes, for Resident #05 and Resident #06, were reviewed for a period of approximately one month and indicated that there were at least four separate incidents, witnessed by staff, where Resident #05 had approached, inappropriately touched or exhibited behaviour of a sexual nature towards Resident #06 and on one occasion Resident #13.

Progress notes reviewed specific to Residents #05 and Resident #06 all indicate that the families of these residents were not notified by the home, of incidents of resident-resident sexual abuse, until the next day. There is no indication that the family of Resident #13 was contacted regarding the incident.

Staff #51 and the Director of Care both indicated that families are to be notified of incidents of alleged, suspected or witnessed abuse immediately.

Director of Care indicated that the incident between Resident #05 and Resident #06, which occurred on a specific date, was most likely not reported to the family following the occurrence as staff did not realize Resident #05 had physically touched Resident #06 until later that shift.

The Director of Care submitted a second Critical Incident Report (CIR) on a specific date with regards to resident to resident sexual abuse, involving Resident #05 and Resident #06.

The CIR provided explicit details relating to the witnessed incident of resident to resident sexual abuse which had occurred between Resident #05 and Resident #06.

Family of Resident #06 indicated being contacted by the home three times since Resident #06's admission as to the resident being sexually assaulted. Family indicated their loved one is not able to give consent; family further indicated being upset that the incidents between Resident #06 and Resident #05 continue to occur. Family indicated that interventions the home has in place are not effective in keeping their loved one safe.

Progress notes, reviewed for a period of twelve days detail at least five incidents where Resident #05 approached, inappropriately touched or exhibited inappropriate sexual behaviours towards Resident #06.

The written care plan for Resident #06, fails to provide direction to staff and others as to how Resident #06 will be safe-guarded from Resident #05's advances, despite numerous incidents and despite the Critical Incident Report indicating that the care plan had been updated.

Staff interviewed indicated the following:
- attempts have been made to keep Resident #05 and Resident #06 separated but such have not always been successful.
- being aware that safety observation are to be completed for Resident #05; specific staff stated the staffing compliment does not permit adequate time for the observations.

Inspector was advised that as of a specific date, Resident #05 had been placed on 1:1 staffing.

Director of Care indicated, that as of an identified date, Resident #06 had been moved to another area within the home as approved by resident's family.

The home failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 24 (1), by ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, Abuse of a resident by anyone. (as indicated by WN #5)

- The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (a), by ensuring the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse, which resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being. (as indicated by WN #7)

- The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion. (as indicated by WN #7)

- The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (as indicated by WN #8)

- The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care, specific to safe guarding Resident #06. (as indicated by WN #1)

- The licensee failed to comply with LTCHA, 2007, s. 20 (1) by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with. (as indicated by WN #3)

The licensee further failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 76 (4) by ensuring that all staff have received retraining annually relating to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24. (as indicated by WN #6) [s. 19. (1)]

2. Related to Intake #O-001601-15, for Resident #02:

The licensee failed to comply with LTCHA, 2007, s. 19 (1), by ensuring Resident #02 was protected from abuse by anyone.

The Director of Care submitted a Critical Incident Report (CIR) on specific date, with regards to resident to resident sexual abuse.

The CIR provided explicit details of the witnessed incident of sexual abuse which occurred between Resident #01 and Resident #02.

According to Resident #02's clinical health record, resident has a cognition impairment.

Staff #51, Staff #56 and the Director of Care both indicate Resident #02 is unable to provide consent due to cognition impairment.

A review of progress notes, for the period of approximately one month, detail at least six incidents where Resident #01 approached, inappropriately touched and or exhibited sexual behaviours directed toward Resident #02.

Progress notes indicated above note that staff actions included redirection of Resident #01 and telling resident that his/her actions were inappropriate. Staff #51, who is the charge nurse for the home area where residents resided, indicated that Resident #01 targeted Resident #02 and despite redirection from staff, Resident #01 continued to approach, and inappropriately touch Resident #02.

The Manager of Resident and Family Services(MRFS) indicated receiving a written correspondence, from the family of Resident #02 voicing concerns specific to the interactions which were occurring between Resident #01 and #02. The letter concluded with family of Resident #02 indicating that resident was unable to defend self and asked what the home was going to do to protect Resident #02.

Review of Plan of Care for Resident #02 fails to provide clear direction to staff and or others specific to ensuring resident's safety, specific to advances other residents and or as requested by Resident #02's family on two separate dates; nor does the plan of care include any interventions as how staff will safe-guard Resident #02 when approached by Resident #01.

The Assistant Director of Care and the Director of Care both indicated the written care plan should have provided direction to staff as to the safe-guarding of Resident #02.

Director of Care confirmed that there was only one Critical Incident Report, reported to the Director (MOHLTC) relating to resident to resident sexual abuse incident which occurred on a specific date, despite there being approximately six incidents which were witnessed and documented by staff specific to Resident #01 inappropriately touching or exhibiting sexual behaviours towards Resident #02.

Director of Care indicated that the home did not report the other incidents as they felt that since Resident #02 was not distressed by the advances of Resident #01 that the incidents were not determined to be abusive in nature and the interactions were seen more as companion/friendship.

The licensee failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 24 (1) 2., by ensuring the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (as indicated in WN #5)

- The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence. (as indicated in WN #8)

- The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care, specific to safe guarding Resident #02. (as indicated in WN #1)

- The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied

with. (as indicated in WN #3)

- The licensee failed to comply with O. Reg. 79/10, s. 103 (1), by ensuring that a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). (as indicated in WN #9)

The licensee further failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 76 (4) by ensuring that all staff have received retraining annually relating to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24. (as indicated by WN #6)

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Related to Intake #O-001601-15, for Resident #02:

The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring the plan of care set out clear directions to staff and others who provide direct care to the resident, specific to safe-guarding Resident #02.

Resident #02 has a cognition impairment. Resident #02 is dependent on staff for all activities of daily living. Staff and managers interviewed indicated Resident #02 is not able to give consent.

Progress notes, reviewed for the period of approximately one month detail approximately six incidents where Resident #01 approached, inappropriately touched

or exhibited behaviours of a sexual nature towards Resident #02.

Staff interviewed all indicated Resident #01 thought Resident #02 to be of a specific gender and continuously targeted Resident #02. Staff indicated they tried to redirect Resident #01 from Resident #02 but attempts were often short lived or unsuccessful.

Progress notes, dated on two different occasions, indicated that the family of Resident #02 told registered nursing staff that they wanted to ensure Resident #01 was not doing inappropriate things to Resident #02. A letter, dated on a specific date, written by the family of Resident #02, details concerns voiced by the family as to Resident #02's protection and asked as to the home's protocols related to the same.

Another Critical Incident Report was submitted by the Director of Care, on a specific date, relating to resident to resident sexual abuse; the CIR provides details of this incident. According to the CIR, staff intervened and separated the two residents. The CIR indicated that the plan of care was to have been updated following this incident.

The written care plan for Resident #02, fails to provide direction to staff and others as to how Resident #02 will be safe-guarded from Resident #01's advances and or how the home will prevent incidents specific to the incident on and or before this date.

The Assistant Director of Care and the Director of Care both indicated the written care plan should have provided direction to staff as to safe-guarding Resident #02. [s. 6. (1) (c)]

2. Related to Intake #O-001636-15, for Resident #06:

The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring the plan of care set out clear directions to staff and others who provide direct care to the resident, specific to safe-guarding Resident #06.

Resident #06 has a cognition impairment. Resident #06 is dependent on staff for all activities of daily living. Staff and managers interviewed indicated Resident #06 is not able to give consent.

Progress notes, reviewed for a two week period, describe approximately four incidents where Resident #05 approached, inappropriately touched or exhibited behaviours of a sexual nature towards Resident #06.

Staff interviewed, all indicated Resident #05 targeted Resident #06. All staff indicated that it was difficult to keep Resident #05 from approaching Resident #06 despite staff monitoring and redirection.

Two Critical Incident Reports were submitted by the Director of Care, for incidents occurring on two separate occasions, relating to resident to resident sexual abuse. Both CIR's indicated heightened surveillance was in place and the CIR dated for a specific date speaks to the care plan being updated.

The written care plan for Resident #06, fails to provide direction to staff and others as to how Resident #06 will be safe-guarded from Resident #05's advances. The written care plan was finally revised on a specific date to include, Resident #06 is not cognitively capable of consenting to sexual interactions with another resident and that the family is not okay with Resident #06 being touched or engaging in sexual actions with other residents; staff are to prevent incidents if foreseen and separate the two residents.

The Assistant Director of Care and the Director of Care both indicated the written care plan should have provided direction to staff as to safe-guarding Resident #06, prior to the identified date. [s. 6. (1) (c)]

3. Related to Log # O-001569-15, for Resident #04:

The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c) , by ensuring that the plan of care set out clear directions to staff and others who provide direct care to the Resident #04 specific to individualized skin and wound care/management.

Progress notes reviewed during the period of approximately two months, indicated Resident #04 developed a skin condition on a specific date, according to the progress notes, the skin condition worsened.

Progress note, for a specific date and written by Staff #56, indicated Resident #04 continued to develop altered skin integrity issues. Staff #56 indicated in his/her progress note, that a specific intervention was preformed as per consult with Registered Nurse. Progress note indicated that Resident #04 tolerated the procedure well and that staff were to continue to monitor.

Staff #56 indicated that at the time of performing the procedure nursing staff nor the physician were aware of the reason for Resident #04's altered skin integrity condition.

The plan of care in place at the time of the above procedure indicated the following:
- interference with structural integrity of layers of skin related to unknown origin.
Interventions listed include, follow organizational skin and wound care algorithms.

According to progress notes and physician's orders, resident was referred to a specialist and was provided a diagnosis on a specific date; appropriate treatment was prescribed at this time.

A review of the home's policies, Preventative Skin Care (#VII-G-20.05), Skin and Wound Care Management Protocol (#VII-G-20.10) and the Skin and Wound Care Protocol at a Glance-Stage 2 Pressure Ulcers (#VII-G-20.10a) directs that registered nursing staff will adhere to wound management protocols. The policies reviewed failed to provide direction to registered nursing staff specific to the procedure performed by Staff #56 or as directed by the RN.

Director of Care indicated that the actions of Staff #56 were not in keeping with the home's skin and wound care policies.

The written care plan for Resident #04 failed to provide evidence of planned and individualized care specific to resident's skin condition. [s. 6. (1) (c)]

4. Related to Intake #O-001383-14, Resident #07 and Resident #08:

The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c) , by ensuring that the plan of care set out clear directions to staff and others who provide direct care to the resident, related to the use of therapeutic surface based on manufactuer's specifications.

Related to Resident #07:

Resident #07 has chronic discomfort. Resident #07 is indicated as being at risk for alteration in skin integrity.

The following observations were made on a specific date:
- Resident #07 was observed lying in bed on a therapeutic surface; the surface was set to pressure of four with alternate setting of pressure five. Both bed rails were elevated. Resident was sleeping during this observation.

- During a second observation, Resident #07 was observed sitting in bed on a therapeutic surface. The bed surface was set to pressure five. Resident was awake and awaiting meal; resident indicated that the bed surface was too hard and indicated being unaware of what the therapeutic surface's pressure setting was to be set at.

Staff #51 was brought to Resident #07's room to review the therapeutic surface settings; Staff #51 confirmed that the setting was set at pressure setting five. Staff #51 indicated that the therapeutic setting was to be at three and manually changed surface setting from setting five to four in Inspector's presence. When questioned as to why surface setting was changed to setting four (versus three), Staff #51 indicated the setting for resident could be between three or four.

The care plan indicated the following:
- Bed Mobility, requires assistance related to decreased strength and air flow surface on bed. Interventions listed include, ensure air surface is not too firm. Resident #07 prefers it (surface) set at three for comfort. Air surface may be increased to setting five when providing care for additional support; ensure setting is returned to setting three post-care.
- There is another entry in the written plan of care, indicating 'all staff are responsible for checking and monitoring air surface settings and firmness due to entrapment risk.

Resident #07 indicated that often the therapeutic surface setting is left too hard which causes discomfort. Resident indicated telling staff to make sure the surface is not too hard, but despite requests the bed is often too hard and uncomfortable. Resident #07 indicated having no awareness of the setting requirements of the air therapeutic surface.

Related to Resident #08:

Resident #08 is at risk for alteration in skin integrity and currently has skin integrity issues.

The following observations were made during two separate dates:
- Resident was observed lying in bed, asleep and on a therapeutic surface on a specific date; the therapeutic surface setting was set at five, static pressure.
- Resident was observed asleep and lying on a therapeutic surface, during a second date; the therapeutic surface setting was set at eight.

The plan of care indicated the following:

- Bed mobility, resident requires two staff for assistance related to health condition, and being on an airflow surface. Interventions includes, ensure air surface is not too firm. Resident prefers surface set at three for comfort. Air surface may be increased to setting five when providing care for additional support; ensure setting is returned to three post-care.
- The plan of care further indicates resident is at risk for entrapment due to the nature of the air surface.

Staff #51 indicated Resident #08 had a chronic skin condition and the therapeutic surface being over-inflated could potentially places resident at risk for further skin integrity issues or discomfort.

Staff #63 indicated being unaware of settings for therapeutic surface for Resident #08; Staff #63 further indicated never making adjustments to the therapeutic bed settings, and commented that care is provided at the same setting regardless of type of care being provided.

Staff #64 indicated that the therapeutic surface setting is changed to the lowest setting possible when providing care to Resident #08 as the lowest setting allows ease in turning resident with care. Staff #64 indicated being unsure of the settings for the surface but indicated 'most likely the setting is listed in the care plan'.

Staff #51 indicated that staff were aware that setting for therapeutic surface settings were to be set at 3-4 for those residents on air surfaces and further indicated the settings were individualized in each resident's plan of care.

Staff #51 indicated having no knowledge of how pressure settings were assessed or individualized, and having no awareness of any assessment tool used for this purpose or knowing of manufacturer's specifications or guidelines relating to the same.

Director of Care indicated having no knowledge of how pressure settings for the therapeutic surfaces are individually assessed, and was unable to provide a user manual for the therapeutic surfaces.

Director of Care was in agreement, that it would be difficult to provide clear directions to staff when registered nursing staff were unable to determine how residents are assessed for the surfaces and the home not having manufacturers' guidelines for the therapeutic surfaces. [s. 6. (1) (c)]

5. Related to Log #O-001569-15, for Resident #04:

The licensee failed to comply with LTCHA, 2007, s. 6 (5), by ensuring that the resident, the Substitute Decision Maker, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #04's and resident's family expressed wishes are indicated as, if health condition changes, send resident to an acute care hospital without performing cardio-pulmonary resuscitation.

Progress notes reviewed, for a period of approximately two weeks, indicate that Resident #04 had poor intake of food and fluids, was refusing meals, and was noted to have changes in overall health status; according to progress notes on a specific date, resident was found to be unresponsive.

There is no evidence in the clinical health record that the family of Resident #04 was notified of resident’s change in health condition until a specific date and time when the physician ordered Resident #04 to be transferred to hospital.

Staff #51, who is the supervisor assigned to the resident home area, indicated that notification of a family member would be recorded in the individual resident's progress notes and if it wasn't recorded, then it must not have been done.

Staff #51 and the Director of Care both indicated families are to be notified when there is a change in a resident’s health condition. [s. 6. (5)]

6. Related to Intake #O-001383-14, Resident #11:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, relating to nutrition/hydration, assistance at meals, proper positioning when providing nutritional intake and use of assistive devices.

Resident #11 is a risk of choking and or aspiration due to medical and health condition.

The plan of care indicated the following:

- Nutritional risk is high due to resident's condition. Resident requires assistance with eating related to cognition and physical impairment. Goals of care include, resident to have no choking and or aspiration episodes and to maintain adequate nutrition. Interventions listed in the plan includes, resident is to be fed in a specific chair, ensuring chair is elevated so resident is not lying down while eating; Resident to have fluids in own sippy cup with straw; if accepting of food serve food on a plate or in a bowl with spoon, if not accepting give food in own sippy cup. Can feed self, pureed food in sippy cup, requires total physical assistance if being fed using a spoon; Requires 10-12 ½ cup servings per 24 hour; Requires 1:1 supervised feeding at meals and snacks.

Progress note, for a specific date, indicated dietary interventions were revised to include, discontinue the cups with straws; to use sippy cups with lids instead for fluids. (Note: the written care plan was not updated to include this intervention)

The following observations were made during two specific dates:
- Resident was observed in a reclined chair, lying flat on his/her back, while being assisted with fluids (and or food) by Staff #43 and #62 during a specific meal (specific date) and during both meals observed (on a specific date).
- Resident #11 was offered only three teaspoon's of their meal, during the one meal observation (specific date). Staff #43 indicated resident was refusing the meal. Resident was not provided their meal (food) in a sippy cup. It was further noted, that two full cups and one ¾ cup of beverages remained on table in front of resident, all of which were removed from the table following the meal service.
- Staff #62 was observed providing fluids to Resident #11 by inserting straw into beverage cup, placing thumb over end of straw to draw up fluids into the straw, then observed feeding resident fluids by using thumb on straw and releasing, allowing fluids to seep from straw into resident's mouth. Staff #62 was later seen feeding Resident #11 fluids using a nose cup. During both observations during this meal, fluids were visible draining from the resident's mouth onto his/her cheek/chin; resident was heard coughing. This observation was made on a specific date, and during a specific meal.

Staff #44 and #62, Registered Practical Nurse #56, Dietary Manager and Registered Dietitian all indicated Resident #11 was no longer able to feed self, food or fluids, due to a decline in resident's health; Staff #44 and an RPN (working on the unit) indicated that Resident #11 is having increased difficulty with use of a straw. Dietary Manager and Registered Dietitian both indicated, on the date in which interviewed, that they had planned to reassess Resident #11's nutritional risk and needs relating to meal

assistance due to progressive decline during the past few weeks.

Resident #11's plan of care (written care plan) relating to Nutritional Risk / Eating was edited by Registered Nursing Staff #56 on a specific date to read, fluids in own sippy cup with straw or (use of) nosey cup if resident has a hard time sucking liquid up through the straw.

Dietary Manager, on a specific date indicated Resident #11 remains at high risk for choking and or aspiration relating to resident's medical condition and continued health decline; Dietary Manager indicated that the Registered Dietitian had not yet advised him/her of any changes to Resident'11's plan of care and further indicated that Registered Nursing Staff are not permitted to alter or change nutritional or dietary interventions in the plan of care without approval by Registered Dietitian.

Registered Dietitian indicated giving no direction to Staff #56 to alter or change the plan of care regarding nutritional and or dietary interventions and further indicated that staff, including Registered Nursing Staff are not permitted to change the nutritional plan of care without approval by herself or the Dietary Manager, especially as it relates to a resident at high risk for choking and or aspiration.

Dietary Manager and Registered Dietitian both commented that is the expectation that plan of care is to be followed at all times.

It is to be noted (observations, review of progress notes and physician orders during a three day period) that Resident #11's health continued to decline, resulting in the need for continuous monitoring and specific medical interventions; according to the physician's orders, based on symptoms, Resident was being treated for a specific health condition.

A compliance order under LTCHA, 2007, s.6 (7) was previously issued during the Resident Quality Inspection, Inspection #2014_293554_0034. This order was to be in compliance as of January 16, 2015. [s. 6. (7)]

7. Related to Log #O-001569-15, for Resident #04:

The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by ensuring that Resident #04 was reassessed and the plan of care was revised because care set out in the plan had not been effective.

The Director of Care submitted a Critical Incident Report (CIR) for an incident occurring on a specific date. The CIR was submitted with regards to improper/incompetent treatment of a resident that results in harm or risk to a resident.

According to the CIR, Resident #04 was found on a specific date and time unresponsive. The CIR indicates Registered Practical Nurse communicated the change in Resident #04's health status to the Registered Nurse #33, who was in charge of the home, RPN was directed to monitor resident. Resident #04's health continued to decline and resident remained unresponsive; CIR indicates the RPN continued to report decline in resident to RN #33. Registered Nurse #33 did not contact the physician until approximately 2-3 hours later. Physician provided orders to transfer to hospital.

A review of Resident #04's clinical health records, progress notes for a two week period detail resident had been significantly declining; notes indicate Resident #04 had poor intake of food and fluids, was showing signs of dehydration, exhibiting lethargy, and was not self. One progress note indicated resident should be assessed for end of life care.

As of a specific date and time, resident was unresponsive. Progress notes indicate RPN notified RN #33 of Resident #04 having a significant change in health status. Based on the entry in the progress note, RN #33 entered Resident #04's room and noted resident had very little response to uncomfortable stimuli. RN #33 instructed RPN to monitor resident's condition. Progress notes indicate RN #33 did not contact physician until approximately 2-3 hours later, despite RPN voicing concerns.

Resident #04 was transferred to the hospital was admitted to hospital for treatment and heightened monitoring.

The written care plan indicated the following:
- the goal care is intended to achieve includes, resident will have no complications related to medical condition through to the next review period. Interventions direct staff to monitor for signs and symptoms of a specific health condition and to report concerns to the physician.
- Nutritional Risk (high) due to medical condition; goal of care is to control symptoms and to maintain nutrition. Interventions include, to ensure adequate intake, resident requires 12 (1/2) cups of servings/24 hours and to provide oversight, encouragement, cueing with physical assistance when accepted.

Director of Care indicated that RN #33 commented that she had not contacted the physician as he/she did not want to wake the doctor; DOC indicated the home's physician is available 24/7 and waking the physician would not have been an issue.

According to the CIR, RN #33 indicated in a written statement to the Director of Care, that he/she seemed to recall something in the notes that said that the family of Resident #04 was okay with resident being palliative. Director of Care indicated there was no documentation of the health care directive being changed by Resident #04 or resident's family.

The Critical Incident Report, written by the Director of Care indicated that noting the change in Resident #04's health status and resident's health care directive, the physician should have been contacted immediately and or resident transferred to hospital.

Director of Care confirmed that the care provided to Resident #04 and the delay in contacting the physician and or transferring resident to hospital was not based on resident's care needs changing or the resident and or family's expressed wishes.

Director of Care indicated that it would be an expectation that a resident is reassessed if the planned care had not been effective and it is further expected that all registered nursing staff take appropriate action, specifically contacting and or updating the physician when a resident's health condition has changed. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 002, 003 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 there is a process in place and monitored to ensure the plan of care for all residents sets out clear directions to staff and others who provide direct care, specifically as it relates to the use of therapeutic surfaces and individualized skin and wound care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. Related to Resident #07, 08, 09 and 10:

The licensee failed to comply with O. Reg. 79/10, s. 23, by ensuring that staff uses all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, specific to therapeutic surfaces.

Resident #07, 08, 09, and 10, were all observed to be using therapeutic surfaces during specific dates. The plan of care for three of the four resident's indicate the pressure setting was to be at either three or four when the surface was in use and indicated that when care is being provided staff were to increase pressure to level five. There was no pressure settings indicated in Resident #10's plan of care.

Observations during specific dates were not consistent with the planned care for each of the identified residents.

Staff #43 indicated being told by a Registered Nursing Staff approximately a month ago that all therapeutic surfaces were to be set at either 3 or 4 when a resident is in bed and told to increase pressure setting to 5 when providing care or turning a resident on a therapeutic surface, but indicated he/she was unsure as to where to find individualized settings in a resident's plan of care. Staff #43 further indicated being unsure of what is meant by 'static' versus 'alternating' pressure settings.

Staff #63 indicated being unaware of settings for therapeutic surface for Resident #08; Staff #63 further indicated never making adjustments to the therapeutic bed settings, and commented that care is provided at the same setting regardless of type of care being provided. Staff #63 indicated having had no education/training specific to use of therapeutic surfaces.

Staff #64 indicated that the therapeutic surface setting is changed to the lowest setting possible when providing care to a resident, as the lowest setting allows ease in turning resident with care. Staff #64 indicated being unsure of the settings for the therapeutic surface for individual resident's but indicated 'most likely the setting is listed in the care plan'.

Staff #51, who is considered a charge nurse, indicated no awareness of how the bed settings are determined for each individual resident and indicated he/she assumed that all therapeutic low air loss surfaces are set at 3 or 4; Staff #51 indicated that although the plan of care indicates 'resident prefers a specific setting' the resident is not asked, and further indicated that the wording in the plan of care is 'blanket wording or statements'. Staff #51 indicated staff have been trained in the past to change the setting to level 5 when providing care and then to return to a setting of 3 or 4 following care.

During an interview, the Director of Care indicated not being aware as to how pressure settings were determined for those residents using the therapeutic surfaces; she further indicated that the home currently has no manufacturer guidelines or user manuals for the specific therapeutic surfaces. As of as specific date, the DOC informed the inspector that she had contacted the supplier to obtain a copy of the user manual.

The inspector contacted the home's contracted supplier to request a copy of the user manual for review; a copy was provided to the inspector on a specific date.

According to the User Manual (therapeutic surface) the pressure setting guide indicted the following:
- Residents weighing less than 100 pound = Level 1
- Residents weighing 100-125 pounds = Level 2
- Residents weighing 125-200 pounds = Level 3
- Residents weighing 200-350 pounds = Level 4
- Residents weighing over 350 pounds = Level 5

Contracted Supplier Representative indicated that an inservice, specific to use of the therapeutic surface was provided to the home sometime during the Fall of the previous year. The Supplier Representative indicated that the home had been supplied with a tagging system which was to be placed on each of the control units of the therapeutic surface, so that staff were aware of the individualized pressure settings for each resident.

The Supplier Representative indicated that staff were told during the above inservice that the Auto-Firm button (which inflates the surface to highest level of 8-full inflation) which is located on the control unit was to be used when providing care or turning a and then they were to push the auto-firm button again to release the fast inflation mode and return pressure setting to settings individualized for that resident.

According to manufacturer guidelines, and based upon resident's recorded weight, the pressure setting for the indicated residents should have been set at:
- Resident #07 - Level 3
- Resident #08 – Level 3
- Resident #09 – Level 2
- Resident #10 – Level 2 [s. 23.]

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 there is a process in place and monitored ensuring that all staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, specifically as it relates to therapeutic surfaces (e.g. individualized pressure settings), to be implemented voluntarily.

WN #4: 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 failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy, Abuse and Neglect of a Resident, Actual or Suspected (VII-G-10.00) defines sexual abuse as, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff. The policy indicates reportable matters include any incident with respect to alleged, suspected or witnessed abuse of a resident by anyone; every resident has the right to be protected from abuse; all staff have an obligation to report any incident or suspected incident of resident abuse.

The policy, Abuse and Neglect of a Resident, directs the following:
- If a staff member becomes aware of potential or actual abuse, they are to safe-guard the resident immediately and notify the charge nurse.
- The Charge Nurse (RPN) is to assess the resident for injuries and provide medical intervention if indicated; the Charge Nurse (RPN) is to notify the RN in charge of the home.
- The Registered Nurse (charge of the home) is to assess the situation, remove the suspected individual from resident access; notify physician and request a medical assessment; notify family (SDM) of an instance of alleged abuse.
- The Administrator and or Director of Care will provide direction to the RN in charge regarding notification of the police.
- The Administrator or designate will notify Ministry of Health and Long Term Care immediately according to protocols established for reporting abuse and or critical incidents
- The Administrator or designate will ensure the resident is protected from further contact with the implicated person. (Note: Administrator indicated that this policy applies to resident to resident abuse too)

Related to Intake #O-001601-15, for Resident #02:

The Director of Care submitted a Critical Incident Report (CIR) on a specific date, with regards to resident to resident sexual abuse.

Details of the incident were described in the CIR.

Progress notes reviewed for the period of one month document approximately six incidents where Resident #01 was observed approaching, inappropriately touching and or exhibiting behaviours of a sexual nature towards Resident #02. Two progress notes, dated on two separate occasions indicated the family of Resident #02 voiced concerns, to staff and the Director of Care, asking that Resident #01 not be permitted to do inappropriate (sexual) things to Resident #02.

Progress notes indicated above indicate that staff actions included redirect of Resident #01 and telling resident their actions were inappropriate.
Staff #51 indicated that Resident #01 targeted Resident #02 and despite redirection from staff Resident #01 continued to approach and inappropriately touch Resident #02.

Director of Care and staff, who were interviewed, all indicated Resident #02 was not been able to give consent specific to advances of Resident #01. All staff, including Director of Care indicated that they had not considered the advance of Resident #01 towards Resident #02 as abusive in nature as Resident #02 did not seem distressed by the interactions, abuse was not suggested until Resident #02 was physically touched by Resident #01 as per details in the CIR for this specific incident.

Director of Care indicated that there was only one Critical Incident Report, reported to the MOHLTC specific to sexual abuse (resident to resident) incident which occurred on a specific date, despite there being approximately six incidents were staff witnessed Resident #01 inappropriately touching or exhibiting sexual behaviour towards Resident #02. Director of Care indicated that staff and managers felt that since Resident #02 was not distressed by the advances of Resident #01 that the incidents were not determined to be abusive in nature.

The home's policy, Abuse and Neglect of a Resident was not complied with as indicated by:
- As per progress notes reviewed, during a one month period, Resident #02 was not safe-guarded from Resident #01; staff interviewed indicated Resident #01 targeted Resident #02.

- Staff who observed the incident occurring on a specific date did not immediately report the incident to the Registered Practical Nurse nor the Registered Nurse working on the resident home area until approximately three hours later. The staff, who observed the incident, indicated to BSO nurse that following the observation, on a specific date, Resident #01 was redirected from Resident #02 but taken into the dining room where other residents were sitting.
- Progress notes reviewed, during a period of approximately one month, detail approximately six incidents where Resident #01 inappropriately touched or exhibited sexual behaviours towards Resident #02; staff interviewed indicated Resident #02 is unable to give consent due to cognition impairment. The only incident reported to the MOHLTC was incident one specific occasion. [s. 20. (1)]

2. Related to Log #O-001607-15 and #O-001636-15, for Resident #06:

A Critical Incident Report (CIR) was submitted, by the Director of Care, for an incident of Resident to Resident Sexual Abuse; the incident was said to have occurred on a specific date. A Registered Nursing Staff notified the MOHLTC after-hours pager approximately 10 hours following the said incident.

Details of the incident were explicitly described in the CIR.

Progress notes for a specific date, were reviewed, specifically encompassing a time period of approximately eight hours. Notes detail Resident #05 exposing self to Resident #06 and physically making contact with the same resident. Resident #06 pushed back from Resident #05; staff intervened and told Resident #05 the behaviour was inappropriate. Approximately thirty minutes later, Resident #05 was observed pants down and heard repeatedly telling Resident #13 to 'just touch it'; Resident #05 was taken to his/her room by staff and told behaviour was inappropriate. Progress notes indicate Resident #13 was distressed by this incident.

According to the progress notes, the family of Resident #06 and Resident #05 were not notified of the witnessed resident to resident sexual abuse until sometime during the next shift. There is no evidence that the family of Resident #13 was notified.

The home's policy, Abuse and Neglect of a Resident was not complied with as indicated by:
- According to progress notes on a specific date, staff observed Resident #05 exposing self to Resident #06 and provided redirection, telling Resident #05 actions were inappropriate. Progress notes, indicated that approximately thirty minutes later,

Resident #05 was observed with his/her pants down and heard repeatedly telling Resident #13 to 'just touch it'. Resident #05 at this time was taken to his/her room, and told actions were inappropriate. According to the two progress notes, residents residing on the resident home area were not safe-guarded from Resident #05.
- The family of Resident #06 and Resident #05 were not notified of the witnessed resident to resident sexual abuse until the next shift, despite the incidents occurring on mid-day.
- MOHLTC were not immediately notified of the witnessed resident to resident sexual abuse until approximately 10 hours later; registered nursing staff and the Director of Care commented that it was felt that physical contact had not been made, between Resident #05 and Resident #06 at the time of the initial incident.
- Police were not notified of the incident involving witnessed sexual abuse involving two resident's until approximately 11 hours later.

Director Care and the Administrator both indicated it is the expectation that staff follow the home's policies, especially as it relates to zero tolerance of abuse. [s. 20. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1) 2., by ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specific to Abuse of a resident by anyone.

Related to Log #O-001601-15, for Resident #02:

The Director of Care submitted a Critical Incident Report (CIR) on a specific date, with regards to resident to resident sexual abuse, involving Resident #01 and Resident #02.

During an interview, the Director of Care indicated that Resident #02 is unable to give consent due to having a cognitive impairment.

A review of the clinical health record for Resident #02 (and Resident #01) for a period of approximately one month, detail one incident were Resident #01 exhibited sexual behaviours towards Resident #02 and inappropriately touched resident during at least four other occasions.

The Director of Care indicated that all Registered Nursing Staff are considered to be in supervisory roles. The Director of Care indicated that all Registered Nursing Staff

have been provided education specific to LTCHA, 2007, Section 24 and mandatory reporting requirements.

Director of Care indicated that the incident of Resident #01 exhibiting sexual behaviours towards Resident #02 was not reported to the Ministry of Health and Long Term Care as there had been no touching involved and Resident #02 was not distressed by the incident. Incidents of resident to resident specific touching were not reported as the home (staff and managers) felt residents have the right to friendships and again indicated that neither residents was distressed by the interactions and staff felt the interactions appeared consensual. [s. 24. (1)]

2. Related to Log #O-001607-15, for Resident #06:

A Critical Incident Report (CIR) was submitted, by the Director of Care, for an incident of resident to resident sexual abuse; the incident was said to have occurred on a specific date, between Resident #05 and Resident #06.

Details of the incident involving resident to resident sexual abuse are described in the CIR, as submitted by the Director of Care.

According to progress notes, written by Staff #32 (supervisor of resident home area) the above incident occurred on an identified date and time on their shift. Progress notes, written by Staff #32, indicated the Registered Nurse, who was in charge of the home, was notified of the incident of resident to resident sexual abuse a few minutes after incident occurred.

As per the SAC (Spills Action Centre) report , the incident of resident-resident sexual abuse was not reported to the Ministry of Health and Long Term Care until approximately ten hours later.

Director of Care indicated that the home did not report the incident immediately as Staff #32 was not aware that Resident #05 had physically touched Resident #06. [s. 24. (1)]

3. Related to Intake #O-001636-15, for Resident #06:

The Director of Care submitted a Critical Incident Report (CIR) on a specific date, with regards to resident to resident sexual abuse, between Resident #05 and Resident #06. Details of the incident are described in the CIR.

Progress notes reviewed for a period of approximately two weeks were reviewed and detail at least six incidents were Resident #05 approached and inappropriately touched Resident #06.

Incidents, noted in the progress notes, on two separate dates indicate Resident #05 was observed inappropriately touching Resident #06; the incidents were not reported to the Director (MOHLTC) nor was the incident on another date when Resident #05 was observed inappropriately touching an unknown resident.

Director of Care indicated inappropriately touching (specific incidents) had not been considered sexually abusive in the past; DOC indicated the home's staff have 'normalized' the behaviours of residents, seeing such displays (of a sexual nature) as friendly gestures or merely friendships between residents.

Administrator indicated it is the expectation that incidents of abuse whether alleged, suspected or witnessed are to be reported as per legislative requirements.

Administrator indicated that the home as specific date has begun to change their practices and have begun to re-educate staff, including registered staff and managers as to LTCHA, 2007, Section 24 and mandatory reporting requirements. [s. 24. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 76 (4) by ensuring that all staff have receive retraining annually relating to the following:
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24

Staff #50 provided inspector with the previous year's Education Statistics specific to Zero Tolerance of Abuse and Neglect (which includes mandatory reporting under section 24) and Resident Bill of Rights.

Statistics, reviewed for the specific year, indicated the following:
- Zero Tolerance of Abuse and Neglect – 83% completion
- Resident Rights – 0% completion

Staff #50 indicated it is the expectation that all staff and managers complete annual education specific to Prevention of Abuse and Neglect, Mandatory Reporting and Residents Bill of Rights; Staff #50 indicated that there was no reason for staff not to complete their mandatory education as all had several reminders throughout the year.

Administrator indicated being aware that the previous year's annual education specific to Prevention of Abuse and Neglect and Resident Rights had not been completed by all staff and managers. [s. 76. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (a), by ensuring the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse, which resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Related to Log #O-001607-15:

A Critical Incident Report was submitted, by the Director of Care, for an incident of resident to resident sexual abuse; the incident was said to have occurred on a specific date, between Resident #05 and Resident #06.

According to the progress notes, the family of Resident #05 and Resident #06 were not notified of the witnessed resident to resident sexual abuse until sometime during the next day-time shift, despite the incident occurring mid day on a specific date. There is no evidence to support the family of Resident #13 was notified of the incident.

Director of Care indicated that the incident between Resident #05 and Resident #06

was most likely not reported following the occurrence as staff did not realize Resident #05 physically touched Resident #06 until the end of the shift. [s. 97. (1) (a)]

2. Related to Intake #O-001636-15, for Resident #06:

Progress notes reviewed, for a period of approximately two weeks, note at least four incidents in which Resident #05 inappropriately touched Resident #06; there is no indication in the progress notes that family of Resident #06 had been contacted specific to the above incidents nor was there evidence that the family of the unidentified resident on a specified date had been contacted.

Staff #51 indicated that if a family had been contacted, the communications would be captured in the progress notes under the heading 'family note'.

Staff #51 and the Director of Care indicated that families are to be contacted regarding resident incidents. [s. 97. (1) (a)]

3. Related to Log #O-001607-15, for Resident #06:

The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

An incident of resident to resident sexual abuse occurred on a specific date where Resident #05 was inappropriately touching or exhibiting behaviours of a sexual nature towards Resident #06. Resident #06 was said to have moved back in his/her chair in an effort to get away from Resident #05.

Staff #51 contacted the family of Resident #06, during the following day-time shift, to report the incident of resident to resident sexual abuse which had occurred at a specific time the day prior. According to the progress note, written by Staff #51, Resident #06's family requested to be contacted once the home had completed their investigation and report; Staff #51 indicated that family would be contacted by Assistant Director of Care.

Staff #51 indicated that there was no further communications with the family of Resident #06 recorded in the clinical health records.

Assistant Director of Care could not provide evidence to support that the family of

Resident #06 had been contacted to update them on the outcome of the home's investigation specific to the above incident. [s. 97. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #O-001601-15, for Resident #02:

A review of the progress notes, for a period of one month, detail incidents where Resident #01 approached, inappropriately touched or exhibited behaviours of a sexual nature towards Resident #02.

Family of Resident #02 voiced concerns to the Registered Nursing Staff, Manager of Family and Resident Services and the Director of Care, indicating that her loved one was being sexually harassed by Resident #01 and further asked how the home was protecting Resident #02.

Personal Support Worker(s), Registered Nursing Staff and the Director of Care all indicated Resident #02 was unable to give consent due to cognition impairment.

Director of Care indicated that police had not been notified of the incidents (sexual abuse) as both residents had a cognition impairment. [s. 98.]

2. Related to Log #O-001607-15, for Resident #06:

A Critical Incident Report was submitted by the Director of Care, for an incident of witnessed resident to resident sexual abuse, which occurred on a specific date, between Resident #05 and Resident #06.

The incident involved Resident #05 exhibiting behaviours of a sexual nature and making physical contact with Resident #06. Approximately thirty minutes, later, Resident #05 was again see exhibiting behaviours of a sexual nature and heard repeatedly telling Resident #13 'just touch it'.

According to the home's Risk Management Report, written by a Registered Nursing Staff, the police were not notified of this incident until approximately eleven hours later.

Staff #55, who was in charge of the home area, during the shift on the specific date, indicated that staff had reported that Resident #05 exhibited behaviours of a sexual nature towards Resident #06, but indicated staff had commented that there was no physical contact made with Resident #06. RPN #55 reported, that at the end of the shift (approximately seven hours later), staff told him/her that Resident #05's had physically touched Resident #06. Staff #55 indicated the Registered Nurse on shift was made aware of the reported incident and was to follow up. Staff #55 indicated having had been provided training specific to zero tolerance of abuse and that exhibited behaviours of a sexual nature (specific) and remarks such as 'just touch it' could be seen as sexually abusive.

Director of Care indicated that the police were not immediately notified of the incident of sexual abuse as staff had originally thought that Resident #05 had not physically touched Resident #06. [s. 98.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. Related to Log #O-001601-15, for Resident #02:

The licensee failed to comply with O. Reg. 79/10, s. 103 (1), by ensuring that a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

Note: Section 24(1) of the Act
A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

According to documents, provided to the inspector by the home, the Manager of Resident and Family Services (MRFS) received a written correspondence from the Family/Power of Attorney (#25) of Resident #02 on a specific date.

Details of the letter are as follows:

- I am unsure where to address this (concern) as we have already spoken with Staff #57 about this; Resident #01 has been sexually harassing my loved one. Resident #01 has approached Resident #02 flirtatiously; on another two occasions Resident #01 had exhibited behaviours of a sexual nature (specifics) towards Resident #02. We were told the incident(s) did not upset Resident #02 and were told Resident #02 may have touched Resident #01 back, but my family feels this is unacceptable. I have approached Resident #01 and told him/her that my loved one does not want to be touched; this did not deter Resident #01. My loved one would be mortified and disgusted by this type of activity; he/she is unable to defend self. My family and I would like to know what the protocol is for this type of behaviour and how we can

protect Resident #02 from such harassment.

Manager of Resident and Family Services replied (by email) back to Family #25 on the same date letter was received; MRFS indicated being sorry for the situation that was occurring and the stress that the incident(s) was causing to both the family and Resident #02. MRFS indicated that the letter would be forwarded to the Director of Care to follow up. Director of Care indicated receipt of the letter from Resident #02's family.

Director of Care indicated that the correspondence from Family #25 was not forwarded to the Ministry of Health and Long Term Care as the correspondence was not taken as a complaint but an inquiry. [s. 103. (1)]

Issued on this 10 day of September 2015 (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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
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Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : KELLY BURNS (554) - (A1)

Inspection No. / No de l'inspection : 2015_293554_0003 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-0001383 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Sep 10, 2015;(A1)

Licensee / Titulaire de permis : THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet, LINDSAY, ON, K9V-5R8

LTC Home / Foyer de SLD : VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Pamela Kulas

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To THE CORPORATION OF THE CITY OF KAWARTHA LAKES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 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 :

(A1)
The licensee will prepare, implement and submit a corrective action plan to ensure that residents are protected from sexual abuse by other residents.

In addition, the licensee will immediately implement measures and a monitoring
process to protect residents from sexual abuse and to ensure compliance with
legislative requirements.

All staff are to complete a mandatory, comprehensive and interactive education
session offered in various formats to meet the learning needs of adult learners
specific to, Zero Tolerance of Abuse. The education should include, but not limited to:
- definitions of abuse as defined by the regulation(s), with a heightened emphasis of the definition of sexual abuse
- mandatory reporting requirements as outlined in Section 24

- the use of the MOHLTC Abuse Decision Tree Algorithms (as a guide)
- person(s) who are to be notified in incidences of alleged, suspected or witnessed incidents of abuse, specifically sexual abuse
- implementation of appropriate interventions to safe-guard residents from sexual abuse by other residents, ensuring that interventions are captured and individualized in the plan of care to protect all resident s, especially in incidents where the victim and the abuser are cognitively impaired and consent or the provision of consent is unclear and or uncertain
- a review, by all staff and managers, of the home s specific policies relating to: Prevention of Abuse, Mandatory Reporting, Whistle Blowing Protection and the Resident's Bill of Rights

The licensee is to ensure there is a process in place to monitor the effectiveness of
the education and a process to ensure sustained compliance relating to reporting requirements specific to Section 24; notification of required individuals in incidence of alleged, suspected or witnessed abuse, specifically sexual abuse; and the need to ensure appropriate interventions are taken.

The licensee will further ensure that all staff are provided annual re-training specific to Zero Tolerance of Abuse, Resident s Bill of Rights, Mandatory Reporting and Whistle Blower Protection.

The licensee will provide a written plan on or before June 10, 2015; the plan must be submitted in writing and forwarded to the Attention of: LTC Homes Inspector (Nursing) - Kelly Burns, at the following email: kelly.burns@ontario.ca

Grounds / Motifs :

1. The licensee failed to comply with LTCHA, 2007, s. 19 (1), by ensuring that resident are protected by abuse by anyone.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or staff member.

Related to Intake #O-001607-15 and Intake #O-001636-15, for Resident #06:

A Critical Incident Report(CIR) was submitted, by the Director of Care, for an incident of resident to resident sexual abuse, the incident was said to have occurred on a specific date.

The CIR submitted, by the DOC, provides explicit details of the incident of resident to resident sexual abuse which was said to have occurred between Resident #05 and Resident #06, on a specific date.

According to Resident #06's clinical health record, resident has a cognition impairment. Director of Care indicated Resident #06 is unable to give consent. Resident is dependent on staff for all activities of daily living.

Progress notes, for Resident #05 and Resident #06, were reviewed for a period of approximately one month and indicated that there were at least four separate incidents, witnessed by staff, where Resident #05 had approached, inappropriately touched or exhibited behaviour of a sexual nature towards Resident #06 and on one occasion Resident #13.

Progress notes reviewed specific to Residents #05 and Resident #06 all indicate that the families of these residents were not notified by the home, of incidents of resident-resident sexual abuse, until the next day. There is no indication that the family of Resident #13 was contacted regarding the incident.

Staff #51 and the Director of Care both indicated that families are to be notified of incidents of alleged, suspected or witnessed abuse immediately.

Director of Care indicated that the incident between Resident #05 and Resident #06, which occurred on a specific date, was most likely not reported to the family following the occurrence as staff did not realize Resident #05 had physically touched Resident #06 until later that shift.

The Director of Care submitted a second Critical Incident Report (CIR) on a specific date with regards to resident to resident sexual abuse, involving Resident #05 and Resident #06.

The CIR provided explicit details relating to the witnessed incident of resident to resident sexual abuse which had occurred between Resident #05 and Resident #06.

Family of Resident #06 indicated being contacted by the home three times since Resident #06's admission as to the resident being sexually assaulted. Family indicated their loved one is not able to give consent; family further indicated being upset that the incidents between Resident #06 and Resident #05 continue to occur. Family indicated that interventions the home has in place are not effective in keeping their loved one safe.

Progress notes, reviewed for a period of twelve days detail at least five incidents where Resident #05 approached, inappropriately touched or exhibited inappropriate sexual behaviours towards Resident #06.

The written care plan for Resident #06, fails to provide direction to staff and others as to how Resident #06 will be safe-guarded from Resident #05's advances, despite numerous incidents and despite the Critical Incident Report indicating that the care plan had been updated.

Staff interviewed indicated the following:
- attempts have been made to keep Resident #05 and Resident #06 separated but such have not always been successful.
- being aware that safety observation are to be completed for Resident #05; specific staff stated the staffing compliment does not permit adequate time for the observations.

Inspector was advised that as of a specific date, Resident #05 had been placed on 1:1 staffing.

Director of Care indicated, that as of an identified date, Resident #06 had been moved to another area within the home as approved by resident's family.

The home failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 24 (1), by ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, Abuse of a resident by anyone. (as indicated by

WN #5)

- The licensee failed to comply with O. Reg. 79/10, s. 97 (1) (a), by ensuring the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse, which resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being. (as indicated by WN #7)

- The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by ensuring the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion. (as indicated by WN #7)

- The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (as indicated by WN #8)

- The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care, specific to safe guarding Resident #06. (as indicated by WN #1)

- The licensee failed to comply with LTCHA, 2007, s. 20 (1) by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with. (as indicated by WN #3)

The licensee further failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 76 (4) by ensuring that all staff have receive retraining annually relating to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24. (as indicated by WN #6) (554)

2. Related to Intake #O-001601-15, for Resident #02:

The licensee failed to comply with LTCHA, 2007, s. 19 (1), by ensuring Resident #02 was protected from abuse by anyone.

The Director of Care submitted a Critical Incident Report (CIR) on specific date, with regards to resident to resident sexual abuse.

The CIR provided explicit details of the witnessed incident of sexual abuse which occurred between Resident #01 and Resident #02.

According to Resident #02's clinical health record, resident has a cognition impairment.

Staff #51, Staff #56 and the Director of Care both indicate Resident #02 is unable to provide consent due to cognition impairment.

A review of progress notes, for the period of approximately one month, detail at least six incidents where Resident #01 approached, inappropriately touched and or exhibited sexual behaviours directed toward Resident #02.

Progress notes indicated above note that staff actions included redirection of Resident #01 and telling resident that his/her actions were inappropriate. Staff #51, who is the charge nurse for the home area where residents resided, indicated that Resident #01 targeted Resident #02 and despite redirection from staff, Resident #01 continued to approach, and inappropriately touch Resident #02.

The Manager of Resident and Family Services(MRFS) indicated receiving a written correspondence, from the family of Resident #02 voicing concerns specific to the interactions which were occurring between Resident #01 and #02. The letter concluded with family of Resident #02 indicating that resident was unable to defend self and asked what the home was going to do to protect Resident #02.

Review of Plan of Care for Resident #02 fails to provide clear direction to staff and or others specific to ensuring resident's safety, specific to advances other residents and or as requested by Resident #02's family on two separate dates; nor does the plan of care include any interventions as how staff will safe-guard Resident #02 when approached by Resident #01.

The Assistant Director of Care and the Director of Care both indicated the written

care plan should have provided direction to staff as to the safe-guarding of Resident #02.

Director of Care confirmed that there was only one Critical Incident Report, reported to the Director (MOHLTC) relating to resident to resident sexual abuse incident which occurred on a specific date, despite there being approximately six incidents which were witnessed and documented by staff specific to Resident #01 inappropriately touching or exhibiting sexual behaviours towards Resident #02.

Director of Care indicated that the home did not report the other incidents as they felt that since Resident #02 was not distressed by the advances of Resident #01 that the incidents were not determined to be abusive in nature and the interactions were seen more as companion/friendship.

The licensee failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 24 (1) 2., by ensuring the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (as indicated in WN #5)

- The licensee failed to comply with O. Reg. 79/10, s. 98, by ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence. (as indicated in WN #8)

- The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care, specific to safe guarding Resident #02. (as indicated in WN #1)

- The licensee failed to comply with LTCHA, 2007, s. 20 (1), by ensuring the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. (as indicated in WN #3)

- The licensee failed to comply with O. Reg. 79/10, s. 103 (1), by ensuring that a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall

submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). (as indicated in WN #9)

The licensee further failed to comply with the following:

- The licensee failed to comply with LTCHA, 2007, s. 76 (4) by ensuring that all staff have receive retraining annually relating to the following: the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents and the duty to make mandatory reports under section 24. (as indicated by WN #6)

During this critical incident inspection (and complaint inspection) of resident to resident sexual abuse, actual harm and or risk of harm was demonstrated as two vulnerable and cognitively impaired residents were recipients of the sexual abuse. These incidents re-occurred over a time period of several weeks to a month for Resident #02 and Resident #06 while residents were residing in the home. Personal Support Workers, Registered Nursing Staff and Managers indicated that interactions between Resident #06 and Resident #05 were considered consensual despite all staff and managers interviewed indicating Resident #06 was unable to provide consent. (554)

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

Oct 26, 2015(A1)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:
- review and update Resident #11's, and all other residents with similar needs, plan of care to ensure planned care is individualized and meeting the needs of the resident
- implement measures and a monitoring process to ensure that the care set out in the plan of care is provided to Resident #11 and all resident's with a similar need as Resident #11, specifically as it relates to nutrition and hydration, assistance required with activities of daily living (specifically during meal times) and proper positioning when providing nourishment.
- provide re-instruction to all registered nursing staff specific to care planning, and ensuring that the plan of care meets the needs of each resident
- provide re-instruction to all direct care staff as to the importance of providing care as specified in the plan of care, specifically as it relates to assistance with activities of daily living; direct care staff are to be made aware of who they are to contact if the planned care can't be provided or if the planned care is not effective, so that appropriate and timely action can be taken

Grounds / Motifs :

1. Related to Intake #O-001383-14, Resident #11:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, relating to nutrition/hydration, assistance at meals, proper positioning when providing nourishment and use of assistive devices.

Resident #11 is a risk of choking and or aspiration due to medical and health condition.

The plan of care indicated the following:

- Nutritional risk is high due to resident's condition. Resident requires assistance with eating related to cognition and physical impairment. Goals of care include, resident to have no choking and or aspiration episodes and to maintain adequate nutrition. Interventions listed in the plan includes, resident is to be fed in a specific chair, ensuring chair is elevated so resident is not lying down while eating; Resident to have fluids in own sippy cup with straw; if accepting of food serve food on a plate or in a bowl with spoon, if not accepting give food in own sippy cup. Can feed self, pureed food in sippy cup, requires total physical assistance if being fed using a spoon; Requires 10-12 ½ cup servings per 24 hour; Requires 1:1 supervised feeding at meals and snacks.

Progress note, for a specific date, indicated dietary interventions were revised to include, discontinue the cups with straws; to use sippy cups with lids instead for fluids. (Note: the written care plan was not updated to include this intervention)

The following observations were made during two specific dates:
- Resident was observed in a reclined chair, lying flat on his/her back, while being assisted with fluids (and or food) by Staff #43 and #62 during a specific meal (specific date) and during both meals observed (on a specific date).
- Resident #11 was offered only three teaspoon's of their meal, during the one meal observation (specific date). Staff #43 indicated resident was refusing the meal. Resident was not provided their meal (food) in a sippy cup. It was further noted, that two full cups and one ¾ cup of beverages remained on table in front of resident, all of which were removed from the table following the meal service.
- Staff #62 was observed providing fluids to Resident #11 by inserting straw into beverage cup, placing thumb over end of straw to draw up fluids into the straw, then observed feeding resident fluids by using thumb on straw and releasing, allowing fluids to seep from straw into resident's mouth. Staff #62 was later seen feeding Resident #11 fluids using a nose cup. During both observations during this meal, fluids were visible draining from the resident's mouth onto his/her cheek/chin; resident was heard coughing. This observation was made on a specific date, and during a specific meal.

Staff #44 and #62, Registered Practical Nurse #56, Dietary Manager and Registered Dietitian all indicated Resident #11 was no longer able to feed self, food or fluids, due

to a decline in resident's health; Staff #44 and an RPN (working on the unit) indicated that Resident #11 is having increased difficulty with use of a straw. Dietary Manager and Registered Dietitian both indicated, on the date in which interviewed, that they had planned to reassess Resident #11's nutritional risk and needs relating to meal assistance due to progressive decline during the past few weeks.

Resident #11's plan of care (written care plan) relating to Nutritional Risk / Eating was edited by Registered Nursing Staff #56 on a specific date to read, fluids in own sippy cup with straw or (use of) nosey cup if resident has a hard time sucking liquid up through the straw.

Dietary Manager, on a specific date indicated Resident #11 remains at high risk for choking and or aspiration relating to resident's medical condition and continued health decline; Dietary Manager indicated that the Registered Dietitian had not yet advised him/her of any changes to Resident'11's plan of care and further indicated that Registered Nursing Staff are not permitted to alter or change nutritional or dietary interventions in the plan of care without approval by Registered Dietitian.

Registered Dietitian indicated giving no direction to Staff #56 to alter or change the plan of care regarding nutritional and or dietary interventions and further indicated that staff, including Registered Nursing Staff are not permitted to change the nutritional plan of care without approval by herself or the Dietary Manager, especially as it relates to a resident at high risk for choking and or aspiration.

Dietary Manager and Registered Dietitian both commented that is the expectation that plan of care is to be followed at all times.

It is to be noted (observations, review of progress notes and physician orders during a three day period) that Resident #11's health continued to decline, resulting in the need for continuous monitoring and specific medical interventions; according to the physician's orders, based on symptoms, Resident was being treated for a specific health condition.

A compliance order under LTCHA, 2007, s. 6 (7) was previously issued during the Resident Quality Inspection, Inspection #2014_293554_0034. This order was to be in compliance as of January 16, 2015.
(554)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Jun 19, 2015

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee shall:
- review and or revise Resident #04's, and all other residents with a similar need, especially those requiring end of life care, to ensure the planned care is individualized and is currently effective
- implement measures and a monitoring process to ensure that all residents are being reassessed and the plan of care is being reviewed and revised when the planned care for a resident has not been effective, especially those exhibiting significant change and those residents with palliative or end of life care needs
- provide re-instruction and or reinforce to all registered nursing staff the importance of completing timely assessments when a resident exhibits a change in their health and or well-being; re-instruct all registered nursing staff that consideration of different approaches is necessary when the planned care has not been effective; and that it is imperative that appropriate actions and timely response is carried out accordingly

Grounds / Motifs :

1. Related to Log #O-001569-15, for Resident #04:

The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by ensuring that Resident #04 was reassessed and the plan of care was revised because care set out in the plan had not been effective.

The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by ensuring that Resident #04 was reassessed and the plan of care was revised because care set out in the plan had not been effective.

The Director of Care submitted a Critical Incident Report (CIR) for an incident occurring on a specific date. The CIR was submitted with regards to improper/incompetent treatment of a resident that results in harm or risk to a resident.

According to the CIR, Resident #04 was found on a specific date and time unresponsive. The CIR indicates Registered Practical Nurse communicated the change in Resident #04's health status to the Registered Nurse #33, who was in charge of the home, RPN was directed to monitor resident. Resident #04's health continued to decline and resident remained unresponsive; CIR indicates the RPN

continued to report decline in resident to RN #33. Registered Nurse #33 did not contact the physician until approximately 2-3 hours later. Physician provided orders to transfer to hospital.

A review of Resident #04's clinical health records, progress notes for a two week period detail resident had been significantly declining; notes indicate Resident #04 had poor intake of food and fluids, was showing signs of dehydration, exhibiting lethargy, and was not self. One progress note indicated resident should be assessed for end of life care.

As of a specific date and time, resident was unresponsive. Progress notes indicate RPN notified RN #33 of Resident #04 having a significant change in health status. Based on the entry in the progress note, RN #33 entered Resident #04's room and noted resident had very little response to uncomfortable stimuli. RN #33 instructed RPN to monitor resident's condition. Progress notes indicate RN #33 did not contact physician until approximately 2-3 hours later, despite RPN voicing concerns.

Resident #04 was transferred to the hospital was admitted to hospital for treatment and heightened monitoring.

The written care plan indicated the following:
- the goal care is intended to achieve includes, resident will have no complications related to medical condition through to the next review period. Interventions direct staff to monitor for signs and symptoms of a specific health condition and to report concerns to the physician.
- Nutritional Risk (high) due to medical condition; goal of care is to control symptoms and to maintain nutrition. Interventions include, to ensure adequate intake, resident requires 12 (1/2) cups of servings/24 hours and to provide oversight, encouragement, cueing with physical assistance when accepted.

Director of Care indicated that RN #33 commented that she had not contacted the physician as he/she did not want to wake the doctor; DOC indicated the home's physician is available 24/7 and waking the physician would not have been an issue.

According to the CIR, RN #33 indicated in a written statement to the Director of Care, that he/she seemed to recall something in the notes that said that the family of Resident #04 was okay with resident being palliative. Director of Care indicated there was no documentation of the health care directive being changed by Resident #04 or

resident's family.

The Critical Incident Report, written by the Director of Care indicated that noting the change in Resident #04's health status and resident's health care directive, the physician should have been contacted immediately and or resident transferred to hospital.

Director of Care confirmed that the care provided to Resident #04 and the delay in contacting the physician and or transferring resident to hospital was not based on resident's care needs changing or the resident and or family's expressed wishes.

Director of Care indicated that it would be an expectation that a resident is reassessed if the planned care had not been effective and it is further expected that all registered nursing staff take appropriate action, specifically contacting and or updating the physician when a resident's health condition has changed.

During this critical incident inspection Resident #04 exhibited a significant change in his/her overall health and well-being, during a period of approximately two weeks. During a shift on a specific date and time, Resident #04 was noted to be extremely lethargic; resident was found unresponsive at a specific date and time. Despite being notified of resident's change in health and continued to decline, Registered Nurse, in charge of the home, failed to consider different approaches to care or take appropriate actions, specifically notifying the physician or transferring Resident #04 to hospital, thereby delaying necessary medical care and or interventions.
(554)

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

Jun 19, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 10 day of September 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KELLY BURNS

Service Area Office /
Bureau régional de services : Ottawa