Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 11, 2015	2015_293554_0015	O-002379-15	Resident Quality Inspection

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), CAROLINE TOMPKINS (166), KARYN WOOD (601), LYNDA BROWN (111), PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 24-28, August 31, and September 01-04, 2015

The following intakes were completed concurrently with the Resident Quality Inspection, #O-000959-14, O-001129-14, O-001156-14, O-001195-14, O-001206-14, O-001238-14, O-001258-14, O-001352-14, O-001732-15, O-001768-15, O-001798-15, O-001860-15, O-001901-15, O-001915-15, O-002081-15, O-002143-15, O-002169-15, O-002231-15, O-002240-15, O-002249-15, O-002250-15, O-002293-15, O-002325-15, O-002402-15, O-002600-15, O-002635-15, and #O-002679-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Resident and Family Services, Manager of Building Services, Food Services Manager, Office Manager, Director of Human Resources, Life Enrichment Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), Activity Aides, Dietary Aides, Housekeeping Aides, Scheduling Clerk, Maintenance Staff, Members of the Behaviour Support Team, Physiotherapist, Physiotherapy Assistant, Medical Advisor, Residents, and Families.

During the course of the inspection, the inspector(s) completed an initial tour of the home,
observed dining service, reviewed health care records, reviewed Resident & Family Council
meeting minutes, maintenance general work requisitions, and reviewed policies relating to, Restraints, Personal Assistance Services Device(PASD), Prevention of Abuse and Neglect, Maintenance and Housekeeping, Responsive Behaviours, Management of Complaints, Falls Prevention and Management, Continence and Bowel Care Management

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **14 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #003	2015_293554_0003	554 601
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2015_293554_0003	554 601

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by not ensuring that the home, furnishing and equipment are kept clean and sanitary.

The following observations were made during the dates of August 24-28, 2015:
- Privacy Curtains – observed to have brownish staining along curtain panel in tub/shower room #W235 and in specific resident rooms;
- Couches and Chairs – observed to have dark staining on the seating of the couches and some chair, in the centre core lounge, on two resident home areas;
- Toilets – observed to have dark staining around base of toilet and flooring, in several resident washrooms;
- Flooring – observed to have dark brownish-black staining, in several resident washrooms located in rooms;
- Falls Mat(s) – observed stained (dark black staining) on surface, located in two specific resident rooms

A review of the General Work Order requisitions (contained in a booklet) for two specific resident home areas were reviewed, for a specific month, and failed to provide documentation of the above housekeeping needs required; general work order booklet could not be located on the other two home areas (during specific dates during this inspection). Staff indicated the requisition booklets could not be found.

Manager of Building Services indicated the following:
- Privacy curtains are removed and laundered upon resident discharge, yearly and as staff noticed the privacy curtains soiled;
- Couches and chairs on specific resident home areas are stained from general wear and tear; there is currently no plans for replacement of seating in identified resident home

areas
- Flooring in resident rooms and washrooms are cleaned and washed daily; there should be no reason for staining around toilets;
- Staining of floor tiles in resident room and washrooms are permanent (from wear and tear); there is currently no plans for replacement of stained flooring laundered yearly, when a resident is discharged and as needed due to soiling. Manager of Building Services indicated that housekeeping and nursing staff are to communicate using General Work Order requisitions the need for privacy curtains or any other housekeeping needs.

Manager of Building Services indicated it is an expectation that all staff use the General Work Orders for areas requiring additional housekeeping needs; indicating no such requests had been received.

Manager of Building Services further indicated that the home be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by not ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed between the dates of August 24-27, 2015:
- Walls – scuffed (blackish marks), gouged or wall damage (steel beading or dry wall exposed or holes in walls) – located in identified resident rooms; in tub/shower rooms #W135, W235; throughout the hallways on two resident home areas and in resident communal washrooms #W227, E227
- Tiles – ceramic tiles were chipped or missing in tub/shower rooms #W135, and W235; edges were jagged and sharp posing a risk of skin tears or injuries to residents;
- Flooring – flooring tiles were noted to be chipped or cracked outside of tub/shower rooms #W235 and E247; entry to Blue Lounge (second floor); communal washroom #W227 (sub-flooring exposed with dust and debris); and in identified resident rooms. Uneven flooring poses a trip/fall hazard;
- Flooring – cement flooring in tub/shower rooms located in room(s) #W217, W235 and E147 were observed to have areas of exposed 'unsealed' cement;
- Doors – wooden slider doors in resident washrooms, were noted scuffed (blackish marks) and gouged , located in identified resident rooms; and in one respite room;
- Door Frames – observed scuffed (blackish marks) or to have paint chipping in specific resident rooms; and in tub/shower room #E247;

- Transfer poles were noted rusted in tub/shower room(s) #W247, W235 and in communal resident washroom #W127 and in two identified resident rooms;
- Tub – the tub surround (rubber) was loose or missing in tub/shower rooms located in room(s) #W235, E135 and E235;
- Corner Guard – off wall in the Activity Room located on the second floor and outside of a specified resident room;
- Over-bed table – frame rusted – located in a specific resident room;
- Foot board of Bed – laminate lifting or missing in two resident rooms; edges of foot board were noted to be jagged and sharp; sharp edges pose a risk for skin tears and or injury to residents;
- Ceiling – paint lifting in areas and or holes in ceiling noted, located in identified resident rooms; and in a communal washroom #W227
- Sinks – caulking around the sink noted to be cracked; located in identified resident rooms;
- a specific resident room, on a resident home area, was noted by an inspector not to be functioning [s. 15. (2) (c)]

3. Related to Intake #O-001238-14:

A letter of concern, was received by the Ministry of Health and Long Term Care; the letter, written by a member of the public (visitor), indicated that during a tour of the home the visitor and his/her family member found the respite room(s) dismal.

The home has two Respite Rooms.

During the initial tour of the home, on August 24, 2015, the following observations were made:
- the respite room, located on a specific resident home area was observed to have wall damage to the entry of the respite room space; the corner of the wall was gouged in several areas, with dry wall and the corner steel beading exposed;
- the television stand, and wardrobe were observed to have the shellac finish worn off in areas;
- the counter-top vanity, in the washroom (shared), was observed chipped, with a piece of the laminate missing; this is a porous surface and poses an infection control issue due to difficulty with cleaning this area. Also, noted in the washroom, the caulking around the sink (outer edges) was cracked in areas with dark staining to surround the cracked areas.

A review of the General Work Orders (requisitions), for the period of one month, located on all four resident home areas failed to provide documentation of the areas, noted above, needing repair and or replacement.

Director of Building Services indicated that the expectation was that all staff were required to communicate repairs needed within the home, by completing a request for maintenance services in the requisition booklets at each resident home area nursing station.

Manager of Building Services indicated staff had not made mention of these concerns, specific to maintenance requirements in the respite room or other areas of the home, as identified above.

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 the home, furnishings and equipment are kept in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 17 (1) (e), by not ensuring the resident-staff communication and response system is available in every area accessible by residents.

During the initial tour of the home, the following observations were made:
- the auditorium/large activity room, coffee shop/family-resident dining area, chapel, front lobby lounge (new), physiotherapy room (second floor) and the two lounges on an identified resident home area were all noted to not have a staff-resident communication and response system in place

Interviews with Personal Support Workers, Registered Nursing Staff and Manager of Building Services all indicated that the above areas were frequently used by residents residing in the home.

Administrator and the Manager of Building Services, both, indicated the above identified resident areas have never had a communication and response system.

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 the resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Related to Intake #O-001206-14, for Resident #50:

The licensee failed to comply with O. Reg. 79/10, s. 36, by not ensuring staff use safe transferring and positioning devices or techniques when assisting residents.

The Director of Care, submitted a Critical Incident Report (CIR) on an identified date; the CIR indicates, improper/incompetent treatment of a resident that results in harm or risk to a resident; the incident was said to have occurred on a specific date.

The CIR and progress notes (specific date), indicates that Personal Support Worker (PSW) #104 found Resident #50 lying on the floor in a communal washroom. Assessment by registered nursing staff indicated Resident #50 sustained no visible injury.

Resident #50's diagnosis includes, cognitive impairment. The plan of care (last revision on an identified date) indicated, Resident #50 was at risk for falls related to cognitive impairment, decreased strength and balance. Toileting and transferring indicated Resident #50 was to be toileted using two staff and mechanical lift.

The home's policy, Zero Lifts and Transfers Assessment, directs that Personal Support Workers are to lift/transfer resident according to the logo card posted and as reflected in the individual resident's plan of care.

The home's investigation (as per Director of Care) indicated that PSW #103 had transferred Resident #50 onto the toilet by him/herself and then left resident on the toilet; PSW #103 did not communicate to other nursing staff that resident was on the toilet.

Administrator and Registered Nurse #112 indicated PSW #103 failed to follow the home's policies and procedures relating to Zero Lifts and Transfers, specifically:
- Personal Support Worker transferred Resident #50 onto the toilet using a manual one person transfer; Resident #50 was to be transferred using a mechanical and two staff during entire procedure as indicated in the planned care for this resident.

Registered Nurse #112 and Assistant Director of Care indicated that staff are expected to follow the home's policies and procedures to ensure the safety and well-being of each resident.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process and monitoring process in place ensuring staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Intake #O-002081-15:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (a), by not ensuring the behavioural triggers have been identified for the resident demonstrating responsive behaviours (where possible).

Critical Incident Report (CIR) was received by the Director, on an identified date, reporting a resident to resident incident of sexual abuse.

The CIR documentation indicated that 2 Personal Support Workers (PSWs) witnessed Resident #41 touch Resident #60 on specific body parts, while the residents were in the TV room, in the home area. Resident #60 was fully clothed. Staff indicated, Resident #60

is unable to consent to physical touching of this nature by co-resident.

Review of clinical documentation, including the plan of care and interview with PSWs , Registered staff and members of the Behaviour Support Team (BSO) indicated, that during a five month period Resident #41 had a history of specific responsive behaviours.

There is no indication that identifying factors, including triggers, of Resident #41's, were identified when resident was exhibiting responsive behaviours. [s. 53. (4) (a)]

2. Related to Intake #O-002081-15:

The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Critical Incident Report (CIR) was received by the Director on a specific date, reporting a resident to resident incident of sexual abuse. The CIR documentation indicated that two Personal Support Workers (PSW) witnessed Resident #41 touch Resident #60 on specific body parts or areas, while the residents were in the TV room, in the home area . Resident #60 was fully clothed.

Staff indicated, Resident #60 is unable to consent to physical touching of this nature by the co-resident. The two residents have not previously been seen interacting.

Interview with PSW staff, Registered Practical Nurse and the members of the Behaviour Support Team indicated that Resident #41 had seventeen documented incidents of responsive behaviours, which included three incidents of touching of other residents, one incident of non-consensual touching was reported to the Director.

Review of clinical documentation and Resident #41's plan of care for a three month period, did not identify that Resident #41 demonstrated any responsive behaviours There is no evidence that strategies had been developed and implemented to respond to Resident #41's responsive behaviours.

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 behavioural triggers have been identified; and that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 87 (2) (d), by not ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the inspection dates of August 24, through to August 28, 2015 and August 31, 2015, the following rooms were noted to have pervasive odours (strong smelling, resembled the smell of urine):
- Resident washrooms - five specific rooms;
- Communal Resident Washroom – #E127, W127, W227
- throughout the hallways on one resident home area

Housekeeping staff indicated the home uses disinfectant spray on floors, chairs and privacy curtains to aid with the elimination of odours; indicating that in most cases daily cleaning and use of the disinfectant spray are effective in keeping odours to a minimum, but other times the spray is not effective. Housekeeping Staff indicated that if measures (disinfectant spray and cleaning) are not effective in eliminating odours then they would communicate ineffectiveness to their manager; Housekeeping staff indicated awareness of some of the odour issues on resident home areas, but not others.

Manager of Building Services indicated awareness of the odours in resident rooms (two specific rooms), as well as communal washrooms #W127, indicating the malodour was from urine which he/she assumed had seeped into the flooring; Manager of Building Services indicated the home does use a neutralizer to aid with the elimination of odours, but the neutralizer, has been unsuccessful in eliminating odours in the three of the identified rooms; Manager of Building Services indicated that home has received quotes to replace flooring, due to the odours, in three of the eight identified washrooms, as test sites.

Manager of Building Services indicated the expectation is that staff would communicate concerns to him/her, specific to lingering odours within resident rooms and or resident home areas and that no communication of such had been brought to his/her attention, specifically in relation to communal resident washrooms (identfied areas) nor in three of the resident room washrooms identified.

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 are procedures developed, implemented and monitored for addressing incidents of lingering offensive odours., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. Related to Intake #O-002231-15:

The licensee failed to ensure the plan of care related to toileting/dressing was provided to Resident #57 as specified in the plan.

Review of the care plan (in place at time of incident) for Resident #57 indicated:
- The resident requires total assistance with toileting related to cognitive deficit and impaired mobility. Interventions included: will yell out for staff assistance (cannot work call bell) and activate bed alarm when restless; offer resident bedpan/urinal if up in chair; resident does benefit from some toileting, although is still frequently incontinent; staff to toilet resident according to assessed needs (specific toileting schedule identified); staff x 2 provide weight bearing support to transfer on/off the toilet and assistance with hygiene needs and assistant with continence product; totally dependent for the entire process; transfer to bed for product change and hygiene needs.
- The resident requires total staff assistance of two staff with dressing related to cognitive impairment, physical limitations, and poor judgement. Interventions included: compression stockings to be applied to both legs in morning and removed at bedtime; POA has given permission for staff to leave pyjama bottoms off at bedtime (to aide in assistance checking with incontinence and not disturbing resident's sleep).

Review of the home's investigation, into the critical incident report (CIR), resident health record, employee file and interview of HR Director indicated on a specific date and time, Resident #57 was heard by two PSW's calling out for help. The two PSW's found the resident in room with the door shut and the lights turned off. The resident was sitting in tilted wheelchair (in tilted position) and head off the head rest. The resident was complaining of a discomfort. The resident was still wearing day clothes and shirt protector. PSW #130 was assigned to Resident #57 on identified shift. [s. 6. (7)]

2. Related to Intake #O-002240-15:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, specific to communication and visitation by specific individuals.

Family #51 submitted a concern to the Ministry of Health and Long-Term Care, indicating that Person #63 was visiting Resident #52, despite visiting restrictions. Family #51 indicated visiting restrictions were in place due to concern for Resident #52's safety.

Resident #52 has a diagnosis that includes cognitive impairment. Registered Nurse #102 and personal support workers all indicated Resident #52 lacks judgement and is unable to consent.

Visiting Restrictions which were in place as of a specific date, identified that Visitor #63 was not to attend the home to visit Resident #52 without specific visitation arrangements.

Visitation Arrangement (specific details) were posted on the resident health record.

The family of Resident #52, provided the Director of Care, and Administrator with the court ordered visiting restrictions on a specific date.

The Director of Care (DOC) notified the home's staff via electronic communications (Point Click Care) on an identified date of the following:
- We have legal documentation requires Visitor #63 to make arrangements ahead of time with the home if he/she wants to visit Resident #52. Visitor #63 must have a translator with him/her and the visit must be supervised. If you see Visitor #63 on the property without the proper arrangements and/or without a translator, ask him/her to leave

immediately. If he/she refuses, call the police to remove him/her.

Resident #52's plan of care (written care plan, revised on a specific date) indicated the same information as noted above; as well as Resident #52's health record contained a copy of the visiting restrictions.

Progress notes reviewed, indicated that on an identified date, Registered Nurse #102, who is a charge nurse, was alerted by a personal support worker that Resident #52, was being visited by Visitor #63; resident and Visitor #63 was found outside, along with two other visitors (relative of Visitor #63). RN #102 indicated in the progress that Visitor #63 had not informed the home in advance of his/her visit, despite visiting restrictions in place. The progress note, written by RN #102 indicated he/she reminded Visitor #63 of visitation stipulation as indicated by the courts, arranged for a staff member to supervise the remainder of the visit and allowed the visit to continue.

Registered Nurse #102 indicated knowledge of the visiting restrictions and stipulations for visitation. RN #102 confirmed awareness of Resident #52's planned care specific to visitation by Visitor #63; and further indicated awareness of direction by the DOC on a specific date. RN #102 indicated being aware that Visitor #63 had not followed the required arrangements for visitation, but commented, to the inspector, it was his/her decision to allow the visit between Resident #52 and Visitor #63 to continue, as resident was in no distress and was enjoying the visit. RN #102 indicated Visitor #63 was not asked to leave the home (property) nor were police notified.

Registered Nurse #102 indicated contacting Resident #52's substitute decision maker (SDM) following the incident and indicated SDM (#51) was not pleased of the visit by Visitor #63 and that was upset that the visiting restrictions and stipulations were not followed by the home's staff and management.

Director of Care indicated it is the expectation that the each individual resident's plan of care be followed.

Registered Nurse #102 failed to follow the planned care for Resident #52 surrounding visitation by Visitor #63.

Note:
This is not being issued as an order, due to the following reason:
A Critical Incident Inspection was conducted during a specific month, a Compliance

Order, under Plan of Care, LTCHA, 2007, 6 (7), was issued during the inspection. At the time of this inspection, the licensee still had an Order in place relating to LTCHA, 2007, s. 6 (7), with a compliance date of June 19, 2015. Both of the above incidents occurred prior to this date. No further action to be taken at this time. [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 14, by not ensuring that each resident shower has a least two easily accessible grab bars, one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

During the initial tour of the home, the following was observed:
- tub/shower rooms located two resident home areas, did not have a grab bar located on the adjacent wall of the shower stall.

Director of Building Services and a Maintenance Worker, both indicated that were not aware of the rooms not having the grab bar on the adjacent wall of these rooms. [s. 14.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Under O.Reg. 79/10, s.2 (1) physical abuse means, (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Under O.Reg. 79/10, s. 2 (1) emotional abuse means, (a) any threatening, insulting, intimidating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O.Reg. 79/10, s. 2 (1) verbal abuse means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to Intake #O-002143-15:

A Critical Incident Report (CIR) was received on a specific date for a staff to resident abuse incident that occurred on an identified date and time. The CIR indicated Resident #58 reported to an RPN that PSW #123 had "bullied" the resident. The resident indicated the PSW "had got very close to face and yelled" at the resident.

Review of the home's investigation and interview of ADOC and Human Resources Director indicated PSW #123 received performance management for "belittling" and "bullying" of Resident #57.

Therefore, Resident #57 was emotionally abused by a staff member.

2. Related to Intake #O-001798-15:

A Critical Incident Report (CIR) was received by the Director on a specific date for a staff to resident abuse that occurred on an identified date and time. The CIR indicated that PSW #132 witnessed while transferring the resident to bed) PSW #131 swung and hit Resident #53 on the upper body and then stated "you will not hit me". PSW #131 then "roughly lifted/swung" Resident #53 lower extremities off the floor and into the bed

"sending [Resident #53] rolling back in the bed towards the wall".

Review of the home's investigation, progress notes, internal incident report indicated:
- on an identified date and time, while PSW #131 & #132 were putting Resident #53 to bed (via a mechanical lift), Resident #53 exhibited responsive behaviours. PSW #132 reported Resident #53 then "swatted [PSW #131] on the upper body" while the staff member was removing the sling from the lift. PSW #131 "said in a loud voice with an angry face 'don't hit me' and then proceeded to "hit [Resident #53 with an open hand on the upper torso". PSW #131 then "grabbed [Resident #53] lower extremities, and threw resident into bed forcefully". PSW #131 then grabbed towels and left the resident's room. The POA was notified.
-on a specific date and time the resident was assessed as "family concerned that resident having discomfort. POA concerned this was related to incident that occurred on an identified date. The resident was assessed and voiced discomfort during ROM of specific body parts, particularly on one side. The physician was notified and agreed to transfer resident to hospital for assessment; resident returned from hospital, with a diagnosed injury.

Therefore, Resident #53 sustained emotional and physical abuse by a staff member in the home resulting in discomfort and injury.

The licensee further failed to comply with LTCHA, s. 20 (1)(b)(as indicated by Written Notification(WN) #9)

3. Related to Intake #O-001901-15:

A Critical Incident Report (CIR) was submitted to the Director on a specific date for a staff to resident abuse that occurred on an identified date and time. The CIR indicated a Life Enrichment Aide (LEA #137) reported to the RN observing RPN (#115) stating "I'm trying to do my job!" while speaking only a few inches away from the face of Resident #32. The RN emailed the incident to the DOC on an identified date.

Review of the home's investigation, interviews and review of employee records, indicated:
-on specific date (before mealtime) LEA #137 witnessed RPN #115 "speaking very close to the face and in an aggressive manner" towards Resident #32 and stating "I'm trying to do my job". LEA #137 then reported the incident (after mealtime) to RN #122. The RN did not interview the resident or the RPN but observed the RPN "throughout the

remainder of the shift 'to monitor for abuse'". The RN also sent an email to the DOC regarding the incident which was not received by the DOC until the following day.
-a CIR report to the Director was completed on an identified date (day following the incident) by the ADOC. RPN # 115 was interviewed on a specific date but the RN #122 was not interviewed until 12 days later. The RN stated "did not feel the incident required a CIR" (despite indicating observing the RPN for the remainder of the shift "to monitor for abuse"). The RN was informed by the DOC that "allegations were to be reported, investigated, and staff member sent home" (as per the home's policy). The DOC also reminded the RN of a prior incident of failing to immediately report/investigate in the previous year.
- Interview of the HR Manager indicated the RPN and RN received disciplinary action as a result of the incident on the date identified; and that both the RN and RPN were required to retrain on the home's prevention of abuse policy, resident's rights and reporting requirements. Review of the Supervisor Feedback Form (used to indicate disciplinary action) indicated the RPN received disciplinary action for a different incident (a second incident that occurred on a specific date) but there was no indication of the incident involving the RPN engaging in emotional abuse towards Resident #32. The RN received disciplinary action on an identified date (for a different incident that occurred on a specific date), where the RN again failed to immediately report.

Therefore, Resident #32 sustained emotional abuse by a staff member in the home.

The licensee further failed to comply with LTCHA, s. 20 (1)(b) (as indicated in WN #9), LTCHA s. 23 (1)(a) (as indicated by WN #10) and LTCHA, s. 24 (1)(as indicated by WN #11) .

4. Related to Intake #O-001195-14:

A Critical Incident Report (CIR) was received on a specific date for a staff to resident abuse incident that occurred on an identified date and time. The CIR indicated Resident #20 complained to another staff member that PSW #129 handled the resident roughly during a transfer after personal care. Resident #20 indicated PSW #129 was informed by the resident earlier that shift that the resident had been on an outing the day before and was tired and did not want to get up and dressed. PSW #129 insisted on getting the resident up and walked the resident to the bathroom, got the resident dressed and then upon return from the bathroom, "tossed" the resident "into bed". The resident "was very upset".

Review of the home's investigation indicated and interview of HR indicated:
- on a specific date (and time), RPN #100 (reported to the DOC) that Resident #20 had reported PSW #129 had rough handled the resident during care earlier that same date. The resident reported PSW #129 had "forced [Resident #20] to get up and go to the bathroom when [Resident #20 said didn't want to go and despite crying out in discomfort", forced to get dressed" and "picked up by the peri-area and torso and tossed [Resident #20] into bed". Resident #20 also reported PSW #129 "was rude and cruel...I was too upset all shift to eat, pushing me about,... threw me into bed,... it was horrible".
-PSW #129 received disciplinary action as a result of "violating a Resident's Right to Choice" and review of the staff training records indicated that all staff involved in the incident of staff to resident abuse had received annual re-training on prevention of abuse and neglect, and reporting requirements.

Therefore, Resident #20 was the recipient of verbal, emotional and physical abuse resulting in discomfort and emotional distress.

5. Related to Intake #O-002231-15:

A Critical Incident Report (CIR) was received by the Director on a specific date for an improper care/incompetent treatment of a resident that resulted in harm or risk of harm to a resident that occurred on an identified date (and time). The CIR indicated two PSW's responded to Resident #57 calling out from room and found the resident in a tilted wheelchair, in a tilted position, with room lights off and still in day clothes. The resident complained of a headache at that time.

A second Critical Incident Report (CIR) was received by the Director on a specific date for a staff to resident abuse incident that occurred on an identified date (and time). The CIR indicated PSW #124 had reported to the DOC witnessing an incident of verbal abuse by PSW #123 telling Resident #57 "to shut up" in a loud voice while assisting with toileting.

Review of the home's investigation, interview of ADOC & HR Director, indicated:
-on a identified date, PSW #124 was being investigated by the home for regarding the first incident (that occurred on a specific date) as the staff member had not provided care to the resident but did not report to oncoming shift. During the interview of PSW #124, the PSW reported to the DOC witnessing PSW #123 "scream at him-shut up!" and swear at Resident #57. The PSW reported the incident occurred on a specific date (but reported

five days later). The PSW stated this "happens often" and also reported PSW #123 also "make's negative comments" towards Resident #66. The DOC also interviewed PSW #125 and PSW #126 related to the allegation (as they also worked on the same unit during that shift). PSW #125 reported that PSW #123 was also witnessed "intimidating" or "talks down to them or yells at them" (related to Resident # 57, #66, #67 and #68). PSW #126 reported witnessing PSW #123 telling Resident #57 "to shut up" on several occasion. The PSW reported witnessing PSW #123 (on a different shift) flip the lights on (while Resident #57 was sleeping) and was heard swearing. The PSW also reported witnessing PSW #123 (on a different date) "slammed hand flat on table, terrifying not only this resident, but other residents in the dining room" while Resident #62 was sleeping. Both PSW #123 and #124 are no longer working in the home.

Therefore, Resident #57 sustained emotional abuse as the resident was ignored for a period of three hours and then was the recipient of verbal abuse by another staff member. Resident #62, #66 and #67 were also recipients of verbal abuse as they were not treated with dignity. Resident #68 was the recipient of emotional abuse.

The licensee further failed to comply with LTCHA, s.6 (7)(as indicated by WN #6), LTCHA, s. 20 (1)(b)(as indicated by WN #9), LTCHA, s. 23 (1)(as indicated by WN #10), LTCHA, s. 24 (1)(as indicated by WN #11) & O.Reg. 79/10 s.104(1)(as indicated by WN #13).

Note:
An order will not be issued during this inspection, under LTCHA, 2007, s. 19, Duty to Protect, for the following reason:
The licensee was issued a Compliance Order for LTCHA, 2007, s. 19 (1), during a specific inspection, which included non-compliance related to LTCHA, 2007, s.20(1), s. 23 (1), s.24(1); the licensee was issued to be within compliance by a specific date. At time of this inspection, the order for LTCHA, s. 19 (1) remained in effect. No further action to be taken at this time. [s. 19. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to Intake #O-002231-15:

A Critical Incident Report (CIR) was received by the Director on a specific date for a staff to resident abuse incident that occurred on an identified date (and time). The CIR indicated that PSW #124 had reported to the DOC (on a specific date) witnessing an incident of verbal abuse by PSW #123 (on an identified date) telling Resident #57 "to shut up" in a loud voice while assisting with toileting.

Review of the home's investigation indicated that PSW #124, #125 and #126 also reported witnessing staff to resident emotional abuse by PSW #123 towards Resident # 57, #62, #66, #67 and #68 and did not immediately notify the charge nurse.

Interview of the Administrator, the Human Resources, and the ADOC indicated PSW #124, PSW #125 and #126 did not immediately report witnessed incidents of staff to resident verbal and/or emotional abuse that occurred (until approximately a week later) during the investigation of PSW #124 and did not intervene to protect the residents. [s. 20. (1)]

2. Related to Intake #O-001798-15:

Review of the home's policy "Abuse and Neglect of a Resident-Actual or Suspected" indicated under Procedure: (page 2 of 3)
If a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, or co-worker, the following steps must be taken:
1. Safeguard the resident immediately;
2. Notify the Charge Nurse

The RN in charge will interview all witnesses that have knowledge regarding the allegation, including the victim if possible. The Administrator or designate will notify the MOHLTC Director immediately according to protocols established for reporting of abuse and critical incidents.

A Critical Incident Report (CIR) was received by the Director on a specific date for a staff to resident abuse that occurred on an identified date (and time). The CIR indicated that PSW #132 witnessed while transferring the resident to bed, PSW #131 swing and hit Resident #53 on the upper body and then state "you will not hit me". PSW #131 then "roughly lifted/swung" Resident #53 lower extremities off the floor and into the bed "sending [Resident #53] rolling back in the bed towards the wall".

Review of the home's investigation, progress notes, internal incident report indicated:
- on a specific date, while PSW #131 and #132 were putting Resident #53 to bed (via a mechanical lift), Resident #53 exhibited responsive behaviours. PSW #132 reported Resident #53 then "swatted [PSW #131] on upper torso" while the staff member was removing the sling from the lift. PSW #131 "said in a loud voice with an angry face 'don't hit me' and then proceeded to "hit [Resident #53 with an open hand on the upper body". PSW
#131 then "grabbed [Resident #53] lower extremities, threw resident into bed forcefully". PSW #131 then grabbed towels and left the resident's room. PSW
#132 reported " I was shocked and scared of [PSW #131]. PSW #132 then covered the resident with a blanket, left the resident and proceeded to provide care to other residents. PSW #132 then went on break (approximately 20 minutes later) and reported the incident at that time to the RN. The internal incident report (completed by the RN) indicated the incident was not reported to the RN until after PSW #131 had already left the home (approximately 1 hour later). [s. 20. (1)]

3. Related to Intake #O-001901-15:

A Critical Incident Report (CIR) was submitted to the Director on a specific date for a staff to resident abuse that occurred on an identified date (and time). The CIR indicated a Life Enrichment Aide (LEA #137) reported to RN #122 regarding observing RPN (#115) stating "I'm trying to do my job!" while speaking only a few inches away from the face of Resident #32. The RN emailed the incident to the DOC on the same date as the incident occurred.

Review of the home's investigation and interview of Administrator and HR Director indicated RN #122 was not interviewed until 12 days later. The RN stated "did not feel the incident required a CIR" (despite indicating observing the RPN for the remainder of the shift "to monitor for abuse"). The RN was informed by the DOC that "allegations were to be reported, investigated, and staff member sent home" (as per the home's policy). The DOC also reminded the RN of a prior incident of failing to immediately report/investigate in 2014. Both the RN and RPN were required to retrain on the home's prevention of abuse policy, resident's rights and reporting requirements. Review of the Supervisor Feedback Form (used to indicate disciplinary action) indicated the RPN received disciplinary action for a different incident (a second incident that occurred on a different date). The RN received disciplinary action on a specific date (for a different incident that occurred on an identified date), where the RN again failed to immediately report as per the home's policy.

Note:
An order will not be issued during this inspection, under LTCHA, 2007, s. 19, Duty to Protect, for the following reason:
The licensee was issued a Compliance Order for LTCHA, 2007, s. 19 (1), during a specific date, which included non-compliance related to LTCHA, 2007, s.20(1), s. 23 (1), s.24(1); the licensee was issued to be within compliance by an identified date. At time of this inspection, the order for LTCHA, s. 19 (1) remained in effect. No further action to be taken at this time. [s. 20. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(ii) Neglect of a resident by the license or staff.

Related to Intake #O-002231-15:

A critical incident report (CIR) was received by the Director on a specific date for an improper care/incompetent treatment of a resident that resulted in harm or risk of harm to a resident that occurred on identified date (and time). The CIR indicated 2 PSW's responded to Resident #57 calling out from room and found the resident in a tilted wheelchair, in a tilted position, with room lights off and still in day clothes. The resident complained of a discomfort at that time.

Interviews of HR Director/Administrator indicated the charge nurse reported the incident the following date to the DOC, they did not know why the investigation did not begin until five days later, and indicated the investigation should have begun immediately by the charge nurse. The DOC was not in the home to interview. [s. 23. (1) (a)]

2. Related to Intake #O-001901-15:

A critical incident report (CIR) was submitted to the Director on a specific date for a staff to resident abuse that occurred on identified date (and time). The CIR indicated a Life

Enrichment Aide (LEA #137) reported observing an RPN (#115) stating "I'm trying to do my job!" while speaking only a few inches away from the face of Resident #32. LEA #137 reported the incident to the RN. The RN then emailed the incident to the DOC.

Review of the home's investigation, interviews and review of employee records, indicated an internal incident report was completed by the ADOC on the following day which indicated LEA #137 reported to RN #122 that RPN #115 was observed "speaking very close to the face and in an aggressive manner" of Resident #32 stating "I'm trying to do my job". The RN then "observed the RPN" throughout the remainder of the shift to ensure that the RPN "was coping well" and "to monitor for abuse". The ADOC initiated the CIR report to the Director. The RN indicated (12 days later) that the LEA "witnessed the incident before mealtime and was reported to the RN after the meal" and "did not feel the incident required a CIR" despite indicating the RN was observing the RPN for the remainder of the shift "to monitor for abuse".

Therefore, a suspected incident of staff to resident emotional abuse was not immediately investigated as the RN suspected an incident of staff to resident emotional abuse but did not immediately investigate as the RN reported the incident to the DOC (via email) and the RN was not interviewed for a period of 12 days. [s. 23. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person had reasonable grounds to suspect neglect of a resident by the licensee or staff that resulted in harm or risk of harm, that the suspicion and the information upon which it was based, was immediately reported to the Director.

Related to Intake #O-002231-15:

A critical incident report (CIR) was received by the Director on a specific date for a improper care/incompetent treatment of a resident that resulted in harm or risk of harm to a resident that occurred on an identified date (and time). The CIR indicated 2 PSW's responded to Resident #57 calling out from room and found the resident in a tilted wheelchair, in a tilted position, with room lights off and still in day clothes. The resident complained of a discomfort at that time.

Interview of the Administrator indicated the Director was notified the following day when the charge nurse reported the incident to the DOC. The Administrator was unaware why the charge nurse did not call the after-hours number for the Ministry of Health and Long-Term Care. [s. 24. (1)]

2. Related to Intake #O-001901-15:

Review of the home's investigation, interviews and review of employee records, indicated an internal incident report was completed by the ADOC on a specific date which indicated that on the previous date (indicated time), LEA #137 reported to RN #122 that RPN #115 was observed "speaking very close to the face and in an aggressive manner" of Resident #32 stating "I'm trying to do my job". The RN then "observed [RPN #115] throughout the remainder of the shift to ensure that the RPN was coping well" and "to monitor for abuse". The ADOC initiated the CIR (report to the Director) the following day. The RN submitted "an email" to the DOC regarding the incident which was received by the DOC the following day. Interview of RN #122 (12 days later) indicated the LEA "witnessed the incident before mealtime and was reported to the RN after the meal". The RN was informed that allegations of abuse were to be reported, investigated, and staff member sent home as necessary.

Therefore, the RN was in charge, and had reasonable grounds to suspect emotional abuse of a resident (as he/she continued to observe the RPN for the remainder of the shift "to monitor for abuse" and sent an email to the DOC of the concern) but failed to immediately report to the Director a suspected incident of staff to resident emotional abuse.

Note:
An order will not be issued during this inspection, under LTCHA, 2007, s. 19, Duty to Protect, for the following reason:
The licensee was issued a Compliance Order for LTCHA, 2007, s. 19 (1), during an indicated inspection, which included non-compliance related to LTCHA, 2007, s.20(1), s. 23 (1), s.24(1); the licensee was issued to be within compliance by a specific date. At time of this inspection, the order for LTCHA, s. 19 (1) remained in effect. No further action to be taken at this time. [s. 24. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s 31 (3), by not ensuring that the plan of care provides for everything required under subsection (1).

Under LTCHA 2007, s. 31 (1), indicates that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care.

Under LTCHA, 2007, s. 31 (2), indicates restraining of a resident by a physical device may be included in a resident's plan of care, only if all the following are satisfied:
- a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining;
- the restraining of the resident has been consented to by the resident, or, if incapable, a substitute decision maker of the resident with the authority to give that consent

Under LTCHA, 2007, s. 31 (3), if a resident is being retrained by a physical device under subsection (1), the licensee shall ensure:
- the resident is monitored while restrained, in accordance with the requirements provided for in the regulations;
- the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;
- any other requirements provided for in the regulations (O. Reg. 79/10, s. 110) are satisfied.

Related to Resident #34:

Resident #34 was observed on two separate occasions (during this inspection) wearing a seat belt while in a wheelchair. The Resident was unable to release the seat belt when asked. In addition, the seat belt was wrapped around the frame of the armrest and applied too loosely.

In an interview, Staff #121, 120, and #107 indicated that there was no documentation for hourly monitoring for a restraint for Resident #34. Staff #121 and #120 indicated that the seat belt restraint was not in the care plan, nor were there any assessments or reassessments completed. Staff #122 was not aware that Resident #34 had a restraint.

A review of the clinical health record, for Resident #34, failed to provide documented

evidence of assessments, reassessments and monitoring, including resident's response to a restraint.

Related to Resident #15:

Resident #15 was observed on several occasions (during this inspection) with a seat belt on while in a wheelchair. The resident was unable to release the seat belt when asked.

A review of the clinical health record, for Resident #15, failed to provide documented evidence of an order (approval for use) or consent for the seatbelt in use. There was also, no assessment, reassessment and interventions for the restraint (seatbelt).

In an interview, Staff #126 was unable to provide evidence of the fore mentioned.

Related to Resident #21:

Resident #21 was observed on several occasions (during this inspection) with a seat belt on while in a wheelchair and was unable to release the belt. Resident #21 has a diagnosis that includes, cognitive impairment.

A review of the clinical health record, failed to provide documented evidence of monitoring of the seatbelt (restraint), assessment, reassessment, interventions nor resident's response to the restraint.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Related to Intake #O-002231-15:

The licensee failed to comply with O. Reg. 79/10, s. 104 (1) 2, by not ensuring the report to the Director included the following description of the individuals involved in the incident:
(i)names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident,

A Critical Incident Report (CIR) was received by the Director on a specific date, for a staff to resident abuse incident that occurred on an identified date and approximate time. The CIR indicated PSW #124 had reported to the DOC on a specific date, witnessing an incident of verbal abuse by PSW #123 approximately six days earlier, telling Resident #57 "to shut up" in a loud voice while assisting with toileting. The CIR was not amended to include that during the home's investigation, it was identified that other staff were aware of the incident, and staff had also witnessed and/or alleged staff to resident emotional abuse towards four other residents.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Related to Intake #O-000959-14:

The licensee failed to comply with O. Reg. 79/10, s. 107 (4) 3, by not ensuring the Director was informed of the outcome or current status of the individual or individuals who were involved in an incident.

The home submitted a Critical Incident Report (CIR), indicating Resident #70 was ambulatory with use of a mobility aide; resident fell and sustained an injury on a specific date.

A Critical Incident Report was submitted regarding the resident's injury, but was not amended to include the outcome.

The licensee failed to ensure that the resulting outcome of incident was reported to the Director. [s. 107. (4) 3. v.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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Issued on this 12th day of November, 2015

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

Original report signed by the inspector.