Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Mar 27, 2017	2017_594624_0003	000675-17	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

BAIYE OROCK (624), CRISTINA MONTOYA (461), JENNIFER BATTEN (672), KARYN WOOD (601), LYNDA BROWN (111)

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): February 21, 22, 23, 24, 27, & 28, March 1, 2, & 3, 2017

During the RQI the following Critical Incident Logs were inspected concurrently:
Re: Alleged resident to resident abuse and responsive behaviours - 023581-16, 027099-16, 027411-16, 028033-16, 028358-16, 030191-16, 031469-16, 032012-16,
Re: Alleged resident neglect and/or abuse - 016835-16, 023356-16, 025899-16, 026105-16, 029614-16, 001079-17, 003232-17,
Re: Falls - 027963-16, 030241-16, and 030265-16.

In addition, the following complaint logs were inspected:
001444-17 (re: resident care), 001727-17(re: responsive behaviors), and 017526-16 (re: food and dietary concerns)

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Service Manager, the Manager of Dietary Services, the Manager for Resident and Family Services, the Physiotherapist, Bahavioral Support Ontario (BSO) workers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Laundry Aides, the presidents of Residents' and Family Council, residents and family members.

A tour of the home was carried out, an observation of medication administration, several meal services, staff to resident and resident to resident interactions was made. A review was also completed of residents' health records, the Licensee's internal investigations and relevant policies and procedures related to zero tolerance of abuse, falls, responsive behaviors and complaint process.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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.
- **10 WN(s)**
- **6 VPC(s)**
- **0 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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. The licensee has failed to ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to resident #013 related to the use of bed rails.

On a specified date and time, resident #013 was observed by Inspector #461 to be lying down in bed with one-quarter bed side rail in the up position.

A review of resident #013's health care records indicated that the resident's cognitive skills for daily decision making was severely impaired and required a special behaviour symptom evaluation. The care plan indicated that resident #013 had responsive behaviors and required two-staff to assist with all transfers. The written care plan did not identify interventions related to the use of bed side rails.

In interviews conducted on specified dates with PSW #135, RPNs #153 & #154 by Inspector #461 about the use of bed rail for resident #013, the PSW indicated that resident #013 used the bed rail for positioning, and for safety. RPNs #153 and #154 indicated to Inspector #461 that they did not know the resident was using a bed side rail, but assumed that it was probably used for positioning and safety.

In an interview with the DOC on a specified date by Inspector #461, the DOC indicated that resident #013's Substitute Decision Maker (SDM) was notified about the use of bed rail for positioning and safety. The DOC reported that the paperwork was ready to be signed and the care plan was pending to be updated. However, the DOC acknowledged that presently the resident's care plan was not updated to indicate the use of the bed rail

even though the staff were currently using it.

After observations, review of health records, and interviews with the staff; it was determined that the plan of care of resident #013 did not include the use of bed side rail to assist resident with transferring and promote safety. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care for resident #017, related to personal care, set out clear directions to staff and others who provide direct care to the resident.

According to the health care records of resident #017, the resident is totally dependent on staff for provision of personal care. On a several occasions and on different specified dates and times, Inspector #672 observed resident #017 not receiving the personal care the resident was to receive from staff. In interviews conducted on several specified dates and times with PSW #137, RPN#126 and RPN#152, related to the personal care the resident was to receive, all three staff members indicated that the personal care was not provided as resident had responsive behaviors and would not allow care to be provided. Both RPNs, who reported they were responsible for updating resident's #017's care plan, indicated that the Physician was not made aware of the said behaviors and no interventions have been put in place to manage those behaviors. The RPNs went further to indicate that those behaviors should be listed in the resident's plan of care to provide directions to PSW staff who provide direct care to the resident.

A review of resident #017's most recent care plan at the time of the inspection by Inspector #672, revealed that there were no goals or interventions listed in regards to resident #017's personal care and behaviors.

The licensee failed to ensure that the written plan of care for resident #017 set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #043 as specified in the plan, related to falls risk.

Related to log # 026105-16,

A Critical Incident Report was submitted to the Director on a specified date for an alleged staff to resident neglect incident . As per the CIR, resident #043's call bell was activated at a specified time and was not responded to for over an hour.

A review of the written care plan for resident #043 (in place at time of incident) indicated that the resident was at risk for falls related to history of falls/injury, impaired mobility, gait disturbance, and other related medical diagnoses, with specified interventions to be followed by staff to prevent falls.

The care set out in the plan of care was not provided to the resident as the resident's call bell was activated and staff took over an hour to respond which resulted in a risk to the resident. [s. 6. (7)]

4. Related to log # 023356-16,

A Critical Incident Report was submitted to the Director on a specified date for an allegation of staff to resident neglect. The CIR indicated that on a specified date and time, resident #042 was found by PSW #131 & #132 lying in bed in a prolonged position that resulted in injury.

The CIR indicated that though there were interventions in place at the time of the incident, PSW #133 had failed to follow the home's policy on checking and repositioning of the resident while the resident was in bed. PSW received disciplinary actions.

In an interview with the DOC on a specified date, she indicated that PSW #133 had placed the resident into bed at at a specified time with assistance from PSW #138. The DOC indicated that resident #042 should have been checked every hour and repositioned every 2 hours due to the applied interventions in place at the time. The DOC indicated that PSW #133 had failed to follow the policy on checking and repositioning the resident.

Review of health record for resident #042 indicated the resident was no longer in the home. The written plan of care (in place at time of incident) indicated that the resident was to be turned and repositioned every two hours while in bed as resident was unable to perform turning and repositioning independently.

The care set out in the plan of care was not provided to resident #042 as the resident was not repositioned on the identified date and time as per the written plan of care and resulted in injuries. [s. 6. (7)]

5. The Licensee has failed to ensure that the care set out in the plan of care for resident

#060 was provided to the resident as specified in the plan related to responsive behaviours.

Related to log #001079-17,

On a specified date and time, the ADOC contacted the Ministry of Health and Long Term Care (MOHLTC) to report a Critical Incident Report (CIR) related to an alleged staff to resident verbal abuse that occurred on another specified date and time.

According to the submitted CIR, on a specified date and time, RPN #113 submitted a written statement to the DOC indicating that PSW #111 spoke to resident #060 in a loud voice while redirecting resident #060 from the room of resident #061. During the encounter with PSW #111 and resident #060, resident #060 became agitated as a result of the manner in which the resident was addressed by the PSW, attempted to push the PSW. The PSW in return became upset and yelled at the resident, causing the resident to swing at the PSW, hitting the PSW to the face. PSW #111, according to the written statement is reported to have threatened the resident by indicating that the police should be called.

According to the same CIR, approximately half an hour following the incident, resident #060 approached PSW #114. PSW #114 stepped back from resident #060 and loudly indicated that resident #060 did not get to talk to him/her because the resident had hurt people that he/she worked with and then PSW #114 stormed off.

A review of resident #060's clinical health records by Inspector #601 on a specified date indicated that resident #060 had difficulty expressing emotions as well as other responsive behaviors. Interventions in place at the time of the incident to deal with the resident included among others: to allow the resident enough time to express self, provide reassurance and try not to talk over the resident, and staff are to leave the situation and re-approach if resident is unable to calm down.

The care set out in the plan of care for resident #060 was not provided to resident #060 as specified in the plan related to the management of responsive behaviours when approached by staff for redirection on the identified date. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that
(1) the care plan provides clear direction to staff who provide direct care to resident for
(a) resident #013 regarding the use of bed side rail, (b) resident #017 regarding provision of personal care,
(2) the care set out in the plan of care is provided to resident as specified in the plan for
(a) resident #043 regarding timely response to resident's call bells,
(b) every resident requiring frequent checks and repositioning, is checked and repositioned as specified in their plan,
(c) resident #060 regarding management of responsive behaviors, 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 ensure that the resident-staff communication and response system that uses sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

The Long-Term Care Home is equipped with a resident-staff communication and response system that uses sound to alert staff which allows calls to be cancelled only at the point of activation. The communication system also uses a visual, ceiling-mounted display marquis down the center of each hallway that when activated, indicates where the signal is coming from.

Related to log # 025899-16,

A Critical Incident Report was submitted to the Director on a specified date which indicated that the Director was notified of an alleged staff to resident neglect incident that occurred on the same day. The CIR indicated that resident #036 was found on the floor in the resident`s room. The CIR indicated that the resident had rang the call bell at a specified time to go to the bathroom and then attempted to toilet self and fell to the floor. The resident was "visibly upset" and sustained an injury. The CIR indicated that night staff PSWs did not hear the call bell due to the bell being put at "night setting" and day

staff PSWs arrived at 0630 hours, heard the call bell but did not respond as they were receiving report. The day PSW (#117) then proceeded to answer the call bell about 30minutes after it was activated, and found the resident on the floor.

Interview with the Administrator indicated that resident #036 had rang the call bell on the said date and it was not answered for a period of 30 minutes. The Administrator indicated that staff have been instructed to respond to call bells in a timely manner and not to turn down the call bell volume.

In interviews with RPN #103 and RPN #118 on two resident home areas by Inspector #111, both indicated that they turn down call bell volume to "night" mode on afternoon and night shift as the volume is too loud at the nursing station. RPN # 102 on a third resident home area indicated they have the ability to turn the call bell system volume down but day shift does not.

Interview with the Environmental Service Manager (ESM) by Inspector #111 and observation indicated that when the call bell system is turned to night mode, the call bells were not audible in the back hall or in residents' rooms or in tub/shower rooms. [s. 17. (1) (g)]

2. Related to log # 026105-16,

A Critical Incident Report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident. The CIR indicated that resident #043's call bell was activated on an specific date and was not responded to for over an hour. The CIR indicated no negative effect on the resident.

According to the same CIR, "the call bell volume was set at night setting making it difficult to hear above the volume of bed alarms and chair alarms" and the night PSWs did not recall hearing the call bell. [s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system is calibrated to a sound level that is audible to staff from all areas of the home, to be implemented voluntarily.

WN #3: 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:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff.

During an interview with resident #037, by Inspector #111, the resident had indicated an allegation of staff to resident abuse and neglect and indicated ongoing complaints related to care not being provided.

Review of the progress notes for resident #037 indicated on a specified date and time,

the resident reported to RPN #141 regarding a PSW. The resident indicated the PSW had refused to provide requested assistance and told the resident to perform the requested task independently. The resident reported feeling really upset and refused any further care from the PSW. The resident also reported that the PSW unintentionally hit the resident's legs with the lift resulting in pain and that PSW then denied hitting the resident with the lift. The resident stated being upset with the PSW's tone and indicated "it was very rude". The resident had requested to speak to a RN regarding the incident.

Interview with DOC and ADOC by Inspector #111, indicated that RPN #141 had reported the allegation to RN #156 on a specified date. However, the RN did not immediately investigate the allegation. [s. 23. (1) (a)]

2. The Licensee failed to ensure that appropriate action is taken in response to every incident of alleged, suspected or witnessed abuse or neglect that the licensee knows of, or that is reported to the licensee.

Related to log #026105-16,

A Critical Incident Report indicated that the Director was notified on a specified date of an alleged staff to resident neglect incident with no negative outcome to the resident.

Interview with the Administrator by Inspector #111 indicated that resident #036 rang the call bell on a specified date and staff did not respond for a period of 30 minutes leading to a fall of the resident resulting in an injury. The Administrator indicated the two night shift PSWs failed to respond to the call bell in a timely manner and received re-education. The Administrator indicated the outcome of the investigation was unfounded as there was no intent to neglect the resident by the night staff.

Review of the home's investigation indicated:
- PSW # 119, 120 & RPN #121 were working on the unit when the call bell for resident #036 & #043 was activated and did not respond to the call bells. All three staff ended their night shift without responding to the call bells. PSW #119 & #120 indicated they did not hear resident #036 call bell as they were assisting another resident. RPN # 121 was an agency staff and no longer works in the home, but was not interviewed at the time.

-PSW #117, #122, #123 & #124 & RPN #103 who replaced PSW # 119, 120 & RPN #121, recalled hearing the call bells ringing but proceeded to attending the shift change report. Approximately an hour later, PSW #117 proceeded to answer the call bell of

resident #036 and found the resident on the floor in bathroom. The resident was "visibly upset" and stated the call bell had been "ringing for 50 minutes!" . RN #125 assessed the resident and indicated "reviewed neglect algorithm and felt it was neglect". Resident #043 call bell was then answered following discovering the roommate (resident #036 on the floor).
-the investigation also determined that on a specified night shift, resident #043 had rang their call bell and it rang for over an hour. In addition, resident #041 had rang their call bell and the call bell rang for over 26 minutes on the same shift. There was no CIR submitted for this resident.

The only action taken by the home to prevent a recurrence was to re-educate all staff on responding to call bells in a timely manner and occurred after a call bell audit indicated more than one resident had not had their call bells answered in a timely manner. All staff involved in the incidents did not receive the re-training. There was no other actions taken despite the home's investigation indicating that staff were turning the call bell volume down, the call bell audit indicating that several staff failed to respond to the residents call bells, and one resident fell, was upset and sustained an injury as a result which constituted neglect. [s. 23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse or neglect of a resident, that the licensee knows of, or that is reported to the licensee, is immediately investigated and appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #4: 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 that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, has occurred or may occur, they are to immediately reported the suspicion and the information upon which it was based to the Director.

According to Ontario Regulations (O. Reg.) 79/10, s. 2 (1), “verbal abuse” means 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.

During an interview with resident #037, by Inspector #111, the resident had indicated an allegation of staff to resident abuse and neglect and indicated having ongoing complaints related to care not provided.

Review of the progress notes for resident #037 indicated on a specified date and time, the resident reported to RPN #141 regarding a PSW. The resident indicated the PSW had refused to provide requested assistance and told the resident to perform the requested task independently. The resident reported feeling really upset and refused any further care from the PSW. The resident also reported that the PSW unintentionally hit the resident's legs with the lift resulting in pain and that PSW then denied hitting the resident with the lift. The resident stated being upset with the PSW's tone and indicated "it was very rude". The resident had requested to speak to RN regarding the incident.

Interview with DOC and ADOC by Inspector #111, indicated RPN #141 had reported the allegation to RN #156 on a specified date but the RN did not immediately report the allegation to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that the abuse or neglect of a resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that the staffing plan was evaluated and updated at least annually.

Based on WN #7 related to the organized program of personal support services, WN #2 related to issues with the communication and response system in the home, and a complaint from a family member related to staffing issues in the home, the staffing plan of the home was reviewed. The reviewed evaluated plan for 2016, done in September of 2016 (for period September 2015 - September 2016) did not have any summary of changes made to the plan and when those changes were implemented. There was also no record of a staffing plan being evaluated in 2014 and 2015.

During an interview with the Administrator on a specified date, she indicated that an evaluation of the staffing plan was not completed in 2014 and 2015 and as as such, no record exists for those two years. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan is evaluated and updated annually with a summary of the changes made to the plan and the date that those changes were implemented related to staffing mix, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program specifically related to hand hygiene practices when handling food and fluids.

On a specified date, Inspector #672 observed RPN #103 assisting resident #021 on two occasions with a supplement intake. The Inspector noted that the resident took a small amount of supplement, and RPN #103 returned to the computer at the desk. RPN did not perform hand hygiene prior to or following assisting the resident.

On another specified date and time, during the lunch dining observation on a resident home area, Inspector #672 observed Dietary Aide #106 adding the Gherkin pickles to each resident's plate using his/her bare hands while handling other food items and performing other tasks. Hand hygiene was not performed between the different tasks and/or reaching in to the Gherkin pickle dish. On the same day and meal service, Inspector #672 also observed that PSW #109 was removing dirty soup bowls from the dining tables, then serving the main meals without performing hand hygiene. PSWs #107, #108, and #109, were also observed providing residents assistance with their meals, but not performing hand hygiene between residents. Four days later and in the same resident home area, during the lunch meal service, Inspector #461 observed that PSW #160 was serving the soup to residents while pushing the serving cart and checking the diet list binder without performing hand hygiene between tasks. Inspector also observed PSW #160 serving soda crackers using a tong, but instead of placing them on the resident's plate or soup, he/she put the crackers on his/her bare hands, crush them and sprinkle them onto the residents' soups. He/she continued pushing the serving cart and touching the diet list without washing his/her hands when transitioning from dirty to clean tasks.

On yet another specified day, Inspector #672 observed on a different home area that PSW #143 was administering the afternoon nourishment without performing hand hygiene between residents, even though PSW #143 was assisting some residents with their snack and/or fluids, and assisted one resident back to a chair in the lounge area, and moved another resident sitting in a wheelchair. Eight and nine days later and in the same home area Inspector #672 observed PSWs #142 and #144 administering the afternoon nourishment without performing hand hygiene during the pass. PSW #144 provided assistance to two residents, one in the lounge area, and one in the TV room, then returned to the nourishment cart, and continued with administering snacks without performing hand hygiene. The following day, PSW #142 was observed assisting two separate residents, as one of the residents was pushing another resident in a wheelchair. When the PSW #142 returned to the nourishment cart, he/she did not perform hand hygiene prior to administering the snack and fluids to the other residents in the lounge area.

Review of the Home's LTC Infection Prevention & Control policy #IC-G10.10 related to hand hygiene, last revised on April 2016, indicated that all team members and volunteers will practice hand hygiene to reduce the spread of infections, and that some practices included: hand hygiene before handling/consuming food or drink, after contact with body substances or specimens, contaminated or soiled items (laundry, waste, equipment).

In interviews with the Manager of Dietary Services, the DOC and ADOC regarding the home's expectations related to food handling practices during dining and snack services, all indicated that staff are expected to wash their hands when transitioning from dirty to clean surfaces or tasks, when going in and out of the dining room, prior to starting the snack cart and when stopping to assist someone as well as before and after assisting residents during meal and snack services.

Based on the observations, review of the home's hand hygiene policy, and interviews with the DOC, ADOC, and Manager of Dietary Services, the Licensee failed to ensure that staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program specifically related to hand hygiene practices when handling food and fluids, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the organized program of personal support services for the home, met the assessed needs of resident #069.

On a specified date and time a complaint was received by Inspector #624 from a family member who reported that due to staffing issues in the home, the complainant's family member's calls for assistance are not responded to in a timely manner leading to numerous complaints from the resident whenever the complainant visits. The complainant also indicated that he/she finds that his/her mother's clothing are wet with urine when being laundered.

On two consecutive dates, Inspector #624 interviewed resident #068 and #069 who are roommates. Both residents were alert, oriented, and cognitively well. Resident #069 needs total assistance for personal care. On a specified day, resident #068 reported to Inspector #624 that resident #069, had to wait for over an hour to be provided personal care. Resident #068 also indicated that there have been several occasions where resident #069 had to wait a really long time before receiving assistance from staff especially when staff are "working short".

In an interview with resident #069 on a specified date and time, the resident reported to Inspector #624 that there have been numerous occasions when the resident had rang the call bell and waited “too long” before being assisted. On one occasion, according to the resident,the resident had to wait for over an hour to be assisted with personal care. On another occasion, the resident reported having no choice but to accept substitution of a method of care provision as staff were “working short.”

On a specified date and time, PSW #152 and RPN #137, working in the resident home area were resident #069 resides, were interviewed by Inspector #624 and both indicated that they “work short” on the home area most of the time and when that happens, residents don’t get toileted as often as they should, sometimes full baths are replaced with bed baths, residents get put to bed late and call bells don’t get responded to in a timely manner.

A review of Normal Staffing Compliment section of the PSW Staffing Contingency Plan for the identified resident home area indicated that during the day shift (0630 – 1430), and the evening shift (1430 – 2230) there are four PSWs on duty and assigned to provide resident care, with one of the evening PSWs working 4.5 hours.

A review of a calendar kept in the nursing station, showed to Inspector #624 by PSW #152 indicated that for a specified month and year, in the identified resident home area where resident #069 resides, PSW worked one less than the normal staffing complement on 15 days of the month, which included 18 shifts not covered. A review of the Weekly Detail Complementary Report provided by the Home indicated that for the same month and in the same resident home area, staff worked one less than the normal staffing complement on 15 different days of the month.

A review of the call bell report audit for the said month and for the same resident home area indicated that on six separate days and on seven different occasions, mostly when PSWs were working one less than the normal staffing compliment, the call bell of resident #069 rang for 19 - 37 minutes before it was responded to.

During an interview with the Administrator on a specified date, she indicated that whenever someone calls in sick, they follow the Lincensee's staffing contingency plan and if unsuccessful, staff are reassigned around the home based on the needs of the residents in the different home areas.

The licensee failed to ensure that the organized program of personal support services for the home, met the assessed needs of resident #069. [s. 8. (1) (b)]

WN #8: 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 that its written policy that promotes zero tolerance of abuse and neglect of residents was complied with for resident #059 and #060.

A review of the Licensee's Prevention of Abuse and Neglect of a Resident policy number V11-G-10-00 dated January 2015 was completed by Inspector #601. The policy indicated under procedure: if any employee or volunteer witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect; all staff are responsible to immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse in the home.

Related to log #029614-16,

Inspector #601 reviewed a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time. The CIR indicated that on a specified date and time, resident #059's Substitute Decision Maker (SDM) reported to RPN #141 that resident #059 had called the SDM on a given date and reported that a PSW staff member had grabbed the resident's ankles while trying to put on the resident's slippers. According to resident #059's SDM, the PSW was very rude to resident #059.

An investigation was initiated and it was discovered that on a specified date and time resident #059 had reported the allegations of abuse to an unidentified staff member. The CIR indicated that resident #059 had reported that a PSW came into the resident's room at 1800 hour to get the resident up for supper. The CIR indicated that resident #059 was very upset because the PSW did not ask the resident for consent and grabbed the resident's ankles to put the resident's slippers on.

During an interview on a specified date and time RPN #140 indicated to Inspector #601 that resident #059 had described and reported a PSW that had been rough during care. RPN #140 indicated that resident #059 was not able to provide further details about the incident. During the same interview, RPN #140 indicated forgetting to notify the charge nurse of the allegations brought forward by resident #059 regarding a PSW being rough during personal care.

The Director was notified of the incident a day after the incident was reported by the resident to RPN #140.

Related to log #001079-17,

On a specified date and time, the ADOC contacted the Ministry of Health and Long Term Care (MOHLTC) to report a Critical Incident Report (CIR) related to an alleged staff to resident verbal abuse that occurred on another specified date and time.

According to the submitted CIR, on a specified date and time, RPN #113 submitted a written statement to the DOC indicating that PSW #111 spoke to resident #060 in a loud voice while redirecting resident #060 from the room of resident #061. During the encounter with PSW #111 and resident #060, resident #060 became agitated as a result of the manner in which the resident was addressed by the PSW, attempted to push the PSW. The PSW in return became upset and yelled at the resident, causing the resident to swing at the PSW, hitting the PSW to the face. PSW #113, according to the written statement is reported to have threatened the resident by indicating that the police should be called.

According to the same CIR, approximately half an hour following the incident, resident #060 approached PSW #114. PSW #114 stepped back from resident #060 and loudly indicated that resident #060 did not get to talk to him/her because the resident had hurt people that he/she worked with and then PSW #114 stormed off.

During an interview on a specified date and time, the DOC indicated to Inspector #601 that the MOHLTC was called the day after the incident occurred. According to the DOC, on the day before, RPN #113 reported to RN #156 that resident #060 had struck PSW #111 in the face and did not inform the RN about the alleged staff to resident verbal abuse until the following day. The DOC indicated that RPN #113 only submitted a written statement regarding the alleged staff to resident abuse a day after the alleged incident took place.

The DOC indicated that the written statement by RPN #113 provided a day after the alleged incident outlined a more detailed account of the alleged verbal abuse of resident #060.
The Director was notified one day after the alleged incident occured. RPN #140 and RPN #113 did not comply with the licensee's policy related to reporting of abuse. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD used to assist resident #017 with routine activities of daily living were included in the residents' plan of care.

Resident #017 requires total assistance by staff for transferring and mobility, with the resident needing a wheelchair as primary mode of transportation.

Multiple resident observations by Inspector #672 on several days over a one week period noted that resident #017 was tilted while in the wheelchair and not being transported. This information was verified through staff interviews with PSW #115, PSW #137, RPN #126, and RPN #152. RPN#126 and RPN#152 on a specified date indicated to Inspector #672 that resident #017 is tilted in the wheelchair as a fall prevention measure.

A review of the most recent care plan of the resident had no specific focuses/interventions related to restraints and/or PASDs. RPN #126 and RPN #152 both indicated to Inspector #672 that this information should be documented in resident #017's care plan. Inspector #672 interviewed the ADOC on a specified date and time where the ADOC indicated that the tilt wheelchair for resident #017 is considered a PASDs and should be identified in the resident's plan of care.

The Licensee failed to ensure that the resident's tilt wheelchair, as well as its use as a PASD, was included in the plan of care. [s. 33. (3)]

2. The licensee failed to ensure that the use of a PASD by resident #017 to assist with activities of daily living was approved by a physician, registered nurse, registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

Related to resident #017 above, a review of the resident's health records over a specified three month period revealed that there was no signed order for the resident to have a PASD in place, and there was no documentation to support that the use of the PASD was being reviewed on a regular basis. The consent form for the PASD was reviewed by Inspector #672, and was signed by the Substitute Decision Maker (SDM) on specified date and time.

The licensee failed to ensure that the use of a PASD by a resident to assist with activities of daily living was approved by a physician, registered nurse, registered practical nurse, member of the College of Occupational Therapists of Ontario, member of the College of Physiotherapists of Ontario, or any other member person provided for in the legislation. [s. 33. (4) 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home: is investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

A review of the progress notes of resident #037 by Inspector #111 indicated the resident had ongoing verbal complaints over a specified seven months period regarding improper care provision by staff or care not provided. The BSO indicated the resident displayed responsive behaviors, repetitive non-health related complaints as well as health related complaints with interventions put in place to attempt a resolution to the complaints, though the complaints persisted.

The progress notes indicated that on a specified date and time the resident had a complaint of staff to resident neglect and three months later, the resident had identified several complaints to RN # 157 that was put in writing related to care not provided and to concerns about a co-resident.

Interview with ADOC on a specified date indicated she was assisting resident #037 with ongoing complaints of staff not providing proper care. The ADOC indicated that BSO was also involved related to these responsive behaviours. The ADOC indicated she meets regularly with the resident to review concerns. The ADOC indicated unawareness of the

residents complaint on the specified dates above related to staff to resident neglect but indicated the written complaints provided by RN #157 were not received until five days later as the complaints were placed under her door.

Interview of the DOC indicated no awareness of the verbal complaint received by RPN #141 on a specified date and the verbal complaints received by RN #157 three months later and that she had no documented evidence they were investigated and a response provided to the resident.

Review of the home's written and verbal complaints log for 2016 (which includes description of complaint and action taken to resolve the complaint) had no documented evidence of resident #037 ongoing, repetitive, verbal complaints related to improper care or a staff to resident abuse and neglect that was reported by resident #037 on the specified date above. There was also no documented evidence that when resident #037 provided a written list of concerns three months after the specified date, that the complaints were investigated or response provided to the resident of the outcome or what would be done to resolved the complaint. [s. 101. (1) 1.]

Issued on this 6th day of April, 2017

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

Original report signed by the inspector.