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 # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2018	2018_420643_0006	005112-18, 005616-18, 005755-18	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Erin Meadows
2930 Erin Centre Boulevard MISSISSAUGA ON L5M 7M4

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 28, and April 3-6, 2018.

The following Complaint intakes were inspected during this inspection:
Log #005616-18 related to improper transferring and positioning techniques; and
Log #005755-18 related to prevention of abuse.

The following Critical Incident intake was inspected concurrently with this complaint inspection:
Log #005112-18, Critical incident System report (CIS) #2881-000009-18 related to prevention of abuse.

Additional evidence for this inspection was collected by Inspector Slavica Vucko (#210) on March 14, 15, 19 and 20, 2018.

Inspector Praveena Sittampalam #699 attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Acting Director of Nursing Care (DON), Assistant Director of Nursing (DON), Kinesiologist (KIN), Registered Practical Nurses (RPN), RAI-MDS Coordinator (RMC), Personal Support Workers (PSW), residents, and substitute decision makers (SDM).

During the course of the inspection, the inspector(s) conducted observations of residents and the provision of care, record review of resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

3 WN(s)
1 VPC(s)
1 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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of the plan of care, to promote and manage bowel and bladder continence and that the plan was implemented.

a. A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) from the family of resident #001 regarding concerns about several areas of the resident's care and the home's complaint process. Review of the complaint revealed the family member had concerns regarding continence care not being completed properly. The complaint further indicated the resident's room would have an odour and that the resident had not been toileted when needed.

Review of resident #001's health records revealed they were admitted to the home with identified medical diagnoses. Review of Resident #001's Minimum Data Set (MDS) assessment revealed they required extensive assistance from two staff members for the process of toileting. The MDS assessment indicated resident #001 was frequently incontinent.

Observation of resident #001 on an identified date revealed resident #001 was seated in the common lounge area of the unit throughout an identified shift. Observation following an identified meal service revealed that staff did not check resident #001's incontinent product or offer to toilet them until an identified time when PSW #115 asked the resident if they needed to use the washroom. PSW #113 who worked the prior shift, did not check or toilet the resident prior to the end of the shift at an identified time. Observation revealed that when resident #001 was transferred onto the toilet identified articles of care equipment appeared wet, the residents pants were wet and the incontinent product appeared bulky from absorbing fluid.

Review of resident #001's current plan of care accessed March 28, 2018, revealed they required extensive assistance from two staff members to transfer the resident onto the toilet, provide pericare, to apply brief and to adjust clothing. The plan of care indicated that resident #001 was incontinent of bladder, and preferred to use a medium brief. It was indicated resident #001 was frequently incontinent of bowel, and may have occasional episodes of incontinence.

In an interview, PSW #113 stated that resident #001 was incontinent and would be taken to the washroom during care at an identified time of day and whenever they asked. PSW #113 stated staff would check resident #001 when repositioning the resident and when uncomfortable the resident would tell them they wanted to go to the toilet and could ask after meal services if they wanted to go to the toilet.

In an interview, PSW #115 stated resident #001 would be toileted at the start of the identified shift and sometimes the resident would ask to use the toilet. PSW #115 stated resident #001 preferred to use the toilet and would usually toilet them or check and change their brief prior to a specified meal service. PSW #115 additionally stated that if resident #001 asked to go earlier in the evening shift the staff would take them.

In an interview, RPN #114 stated resident #001 had an identified level of continence. RPN #114 further stated that staff would toilet resident #001 at the beginning of the identified shift and then ask them if they needed to go to the washroom or the resident would call out when needing to use the washroom. RPN #114 stated there was no toileting schedule for resident #001, but staff would change them when the staff was doing the toileting on the unit.

b. Due to identified noncompliance with O. Reg. 79/10, s. 51. (2) (b). for resident #001, the sample of residents was expanded to include resident #002.

Review of resident #002's health records revealed they were admitted to the home with identified medical diagnoses and health conditions. Review of resident #002's MDS assessment revealed they were dependent on staff for toileting and required two person assistance. The assessment further revealed resident #002 was frequently incontinent and used pads or briefs.

Review of resident #002's current plan of care revealed they required extensive assistance from two staff to transfer for toileting and required assistance for care related

to toileting. The care plan indicated that resident #002 required total assistance for brief changes. The care plan further indicated that resident #002 was occasionally incontinent and required assistance from staff for toileting.

In an interview, PSW #119 stated that resident #002 was incontinent and that staff would check and change them. In an interview PSW #122 stated that resident #002 would not let staff know if they needed to be toileted and would be toileted during identified periods throughout the shift. PSW #122 stated they had not been putting resident #002 onto the toilet, but transferring them to bed to change the brief. In an interview PSW #121 stated resident #002 did not go to the toilet, but did it in the brief as they were incontinent and was not always easy to toilet them during the day as the resident exhibited identified responsive behaviours.

In an interview, RPN #114 stated resident #002 was incontinent, but may indicate when they needed to go to the washroom. RPN #114 further stated that resident #002 was checked and changed at the start of the shift and routinely following an identified meal service, but did not have a toileting schedule. In an interview RPN #118 stated they had not noticed staff taking resident #002 to the toilet and that they were mostly incontinent. RPN #118 stated there was no toileting program and the care plan had not been individualized to promote and maintain continence.

In an interview, RMC #105 stated resident #002 had an identified continence status. RMC #105 stated resident #002 did not have a toileting schedule, but team members would toilet them when they got up and before or after meals and if they asked to go. RMC #105 acknowledged that resident #002's plan of care was not individualized to promote and maintain continence.

c. Due to identified noncompliance with O. Reg. 79/10, s. 51. (2) (b). for resident #001, the sample of residents was expanded to include resident #003.

Review of resident #003's health records revealed they were admitted to the home with identified medical diagnoses. Review of resident #003's MDS assessment revealed they required extensive assistance from two staff members for toileting. The assessment further revealed resident #003 was incontinent all or almost all of the time and used pads or briefs.

Review of resident #003's current plan of care revealed they required total assistance from two staff to transfer and one staff member for the process of toileting. The plan of

care further revealed resident #003 was incontinent and wore a regular brief to manage incontinence.

In an interview, PSW #121 stated that resident #003 would be changed after an identified meal service as the resident would normally required a change. PSW #121 indicated that staff would usually not toilet resident #003 prior to the arrival of the evening shift. In an interview, PSW #122 stated there was no information in the care plan on when to toilet resident #003, but would do so before and after meals.

In an interview, RPN #118 stated resident #003 was incontinent and required total assistance from staff for toileting. RPN #118 stated staff members would check resident #003 every two to three hours. RPN #118 indicated resident #003 would be checked at identified times as this was the usual routine for all residents. In an interview, RPN #114 stated resident #003 would require toileting assistance daily at an identified time and indicated that this information regarding toileting was not care planned for resident #003.

In an interview, RMC #105 stated resident #003 was incontinent and totally dependent on staff for continence care. RMC #105 further stated resident #003 would be toileted identified times and was unable to communicate when they needed to be toileted. RMC #105 indicated that resident #003's plan of care was not individualized for toileting.

In an interview, Assistant Director of Nursing (ADON) #120 stated that some residents had a toileting routine, and for other residents they would be checked and changed at specified times and before or after meals. ADON #120 further stated that the PSW staff would know the residents and who needed to be toileted at certain times. ADON #120 stated that residents #001, #002 and #003's care plans were not reflective of toileting routines, and acknowledged that residents #001, #002 and #003's care plans had not been individualized to promote and maintain continence. [s. 51. (2) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour care plan was based on an interdisciplinary assessment of the resident's identified responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of day.

A complaint was received by the MOHLTC from resident #001's family member concerning several injuries sustained by the resident, and repeated damage to an item of personal property. A Critical Incident System (CIS) report was submitted to the MOHLTC after video footage was shown to the home from an identified eight day period, of suspected abuse of resident #001.

A review of resident #001's written plan of care revealed they exhibited identified responsive behaviours and required extensive to total assistance for identified activities of daily living (ADL). Interventions to manage the resident's behaviours were:
- always approach resident calmly and unhurriedly;
- speak in a calm voice;
- explain all procedures and reason before performing care;
- be cognisant of not invading resident's personal space;
- be sure you have the resident's attention before speaking or touching,
- when resident is exhibiting identified behaviours; if appropriate stop giving care and try later;
- if strategies are not working, leave the resident and re-approach later;
- allow for flexibility in ADL routine to accommodate resident's mood; and
- monitor resident for any changes in behaviours and report to MD.

Review of the video footage from resident #001's room on two identified dates, revealed the resident exhibited identified behaviours when PSW #108, #109, and PSW #110 provided assistance with an identified ADL at a specified time. The resident exhibited

identified behaviours toward the staff during the above mentioned care. Review of the video footage from an additional identified date and time revealed that when PSW #111 tried to assist resident #001 with toileting the resident exhibited identified responsive behaviours toward the staff member..

The care plan did not indicate that resident #001 exhibited the above mentioned identified responsive behaviours while being provided care. The care plan did not indicate the resident the resident's dislike for certain types of care assistance at certain times of day.

Review of the clinical records revealed that Dementia Observation System (DOS) tool was initiated on an identified date approximately one month prior to the video footage dates, for observation every 30 minutes for a one week period. The DOS tool revealed that resident #001 exhibited a specified responsive behaviour on one occasion at an identified date and time. There were 13 instances of the resident exhibiting a second specified behaviour, and three instances of a third specified behaviour. The DOS form was not completed on an identified shift on two identified dates during the seven day observation period.

In an interview, resident #001’s SDM stated they were concerned as the resident only seemed to exhibit a specified responsive behaviour when being cared for by PSW #109 at a certain time of day.

Review of the support action documentation from the electronic record for the one month period prior to the video footage revealed that resident #001 exhibited an identified responsive behaviour type on 20 occasions, 17 of which were at an identified time of day while PSW #109 provided care. The documentation revealed resident #001 exhibited a second type of responsive behaviour 18 times all of which were at an identified time of day while PSW #109 provided care. Further, a third type of responsive behaviour was exhibited in 22 instances, of which 18 occurred at an identified time of day, while PSW #109 provided care.

In an interview PSW #109 stated they were aware resident #001 disliked a specified care task to be completed at a certain time of day. PSW #109 stated they considered it important to complete the care despite the resident’s identified responsive behaviours toward the staff member. PSW #109 indicated they reported to registered staff on some but not all of the occasions of resident #001’s identified behaviours. Further, PSW #109 confirmed they worked on the two above mentioned shifts during the DOS observation

period, and did not document resident #001's behaviours on the form.

In an interview, RPN #102 stated they were informed by PSW #109 on several occasions about resident #001's behaviour after the care had been performed. RPN #102 acknowledged they did not send a referral to the Behavioural Support Ontario (BSO) team for further assessment.

Interview with the BSO team lead Staff #106 revealed the team was not notified and were not aware of resident #001's responsive behaviours during the identified month. The last time resident had been seen by the Psychogeriatrician was four years prior. BSO lead #106 revealed the BSO support team became aware of resident #001's behaviours on an identified date one week after the video footage was taken, when a referral from registered staff was received. Staff #106 observed resident #001 during an identified ADL and updated the care plan to indicate that the resident does not like an identified care task and staff should stop providing care if the resident says no and re-approach. Staff #106 indicated the staff should have sent a referral to BSO support team in order for the resident to be assessed when they presented with the above mentioned identified responsive behaviours in order for the triggers to be identified.

In an interview with RPN #104 who was the previous BSO program lead, they stated that the DOS form should be filled out at all shifts but had not been completed. Further, the BSO team or the registered staff should have reviewed the DOS assessment tool and the flow sheets for responsive behaviours in order to identify patterns or triggers. Further, RPN #104 indicated the DOS form was reviewed and signed by the Physician after the completion of the observation period, but resident #001's behaviours were not accurately reflected on the form.

A review of the clinical record, interview with BSO lead #106, RPN #104, RPN #102, confirmed that resident #001's care plan did not include identification of the above mentioned responsive behaviours and any potential triggers and variations in resident functioning at different times of the day. [s. 26. (3) 5.]

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 plan of care is based on, at a minimum interdisciplinary assessment of the following with respect to the resident:
- mood and behaviour patterns, including wandering;
- any identified responsive behaviours; and
- any potential behavioural triggers and variations in resident functioning at different times of day, to be implemented voluntarily.

WN #3: 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 physical abuse by anyone.

The following is further evidence to support the order issued on February 22, 2018, during Resident Quality Inspection (RQI) 2018_544527_0001 to be complied by April 27, 2018.

A Critical Incident System (CIS) report was submitted to the MOHLTC on an identified date, after video footage was shown to the home from an eight day period prior to the submission of the CIS, of suspected abuse of resident #001. The MOHLTC received complaints from the family of resident #001 on two identified dates, alleging abuse of the resident as well as concern regarding care of the resident.

Review of resident #001's health records revealed the resident had identified medical the following diagnoses and cognitive impairment. The admission behaviour assessment

from Community Care Access Centre (CCAC) indicated the resident exhibited identified responsive behaviours. The interventions required were to not force the resident in order to manage the resident's identified behaviours.

A review of the video clips from resident #001's room from an identified 11-day period revealed several incidents of abuse:
• At an identified date and time, PSW #109 was attempting to assist resident #001 who was in bed with an identified ADL. Resident #001 was observed to exhibit an identified behaviour toward PSW #109 who turned and walked away. PSW #108 entered the room with PSW #109 and physically restrained resident #001while PSW #109 provided care. The resident exhibited an identifed behavioural response during the provision of care.
• At an identified date and time, PSW #111 attempted to provide continence care to resident #001. A towel was placed over resident #001's hands and chest while PSW #111 was pulling down the resident's pants. Resident #001 was observed to push off the towel, which PSW #111 grabbed and struck at the resident with the towel. PSW #111 then pointed a finger at the resident while speaking to them, then forcefully turned the resident onto their side.
• At an identified date and time, resident #001 was sitting in with PSW #110 standing behind them, with another staff member in the room. PSW #110 was observed to push an identified area of resident #001's body with their hand causing the resident to move forward. Two minutes later, PSW #110 was observed transferring resident #001 into the bed alone, holding the resident by an identified area of their body and by an article of clothing. PSW #110 appeared rough with the resident while performing this transfer. three minutes following the transfer PSW #109 was observed providing care while PSW #110 was standing above the resident holding down their hands with a pillow, then PSW #110 repositioned resident #001 in the bed on their right side in a rough manner.

In an interview, resident #001's SDM stated that the resident had a different reaction when receiving care from PSW #109 and PSW #111 and would exhibit an identified behavioural response in the presence of these staff members. During the inspection resident #001 was not able to articulate whether they had pain resulting from the above incidents due to cognitive impairment.

In an interview, PSW #109 stated they wanted to protect themselves from resident #001 and they called PSW #108 and #110 to hold resident's hands while they provided care. PSW #109 indicated they were aware that resident #001 disliked the identified care task, but felt they had to complete the care. PSW #109 stated that when resident #001exhibited an identified behaviour that meant "no" for staff to stop providing care.

PSW #109 confirmed that the strategies in the written plan of care for managing resident #001's responsive behaviour were not implemented in practice. PSW #109 stated they were aware of the resident right to refuse care, but were not aware that excessive force during care was considered abuse. PSW #109 admitted after seeing the videos, they did not look good and that resident #001 was not protected from abuse.

The home performed investigation and confirmed that staff to resident #001 abuse happened and two PSWs received identified discipline. Interview with the home's General Manager confirmed resident #001 was forcefully restricted from free movement while being provided personal care against their wishes and preferences and they were not protected from abuse. [s. 19. (1)]

Issued on this 4th day of May, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2018_420643_0006
Log No. / No de registre :	005112-18, 005616-18, 005755-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 2, 2018
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Erin Meadows 2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anneliese Krueger

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

For residents #001, #002, #003 and all other residents who are incontinent:
1. Ensure there is an individualized plan to promote and maintain bowel and bladder continence as part of the plan of care that is based on an assessment of the resident; and
2. Ensure the individualized plan to promote and maintain continence is implemented and communicated to direct care staff.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of the plan of care, to promote and manage bowel and bladder continence and that the plan was implemented.

a. A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) from the family of resident #001 regarding concerns about several areas of the resident's care and the home's complaint process. Review of the complaint revealed the family member had concerns regarding continence care not being completed properly. The complaint further indicated the resident's room would have an odour and that the resident had not been toileted when needed.

Review of resident #001's health records revealed they were admitted to the home with identified medical diagnoses. Review of Resident #001's Minimum Data Set (MDS) assessment revealed they required extensive assistance from two staff members for the process of toileting. The MDS assessment indicated resident #001 was frequently incontinent.

Observation of resident #001 on an identified date revealed resident #001 was seated in the common lounge area of the unit throughout an identified shift. Observation following an identified meal service revealed that staff did not check resident #001's incontinent product or offer to toilet them until an identified time when PSW #115 asked the resident if they needed to use the washroom. PSW #113 who worked the prior shift, did not check or toilet the resident prior to the end of the shift at an identified time. Observation revealed that when resident #001 was transferred onto the toilet identified articles of care equipment appeared wet, the residents pants were wet and the incontinent product

appeared bulky from absorbing fluid.

Review of resident #001's current plan of care accessed March 28, 2018, revealed they required extensive assistance from two staff members to transfer the resident onto the toilet, provide pericare, to apply brief and to adjust clothing. The plan of care indicated that resident #001 was incontinent of bladder, and preferred to use a medium brief. It was indicated resident #001 was frequently incontinent of bowel, and may have occasional episodes of incontinence.

In an interview, PSW #113 stated that resident #001 was incontinent and would be taken to the washroom during care at an identified time of day and whenever they asked. PSW #113 stated staff would check resident #001 when repositioning the resident and when uncomfortable the resident would tell them they wanted to go to the toilet and could ask after meal services if they wanted to go to the toilet.

In an interview, PSW #115 stated resident #001 would be toileted at the start of the identified shift and sometimes the resident would ask to use the toilet. PSW #115 stated resident #001 preferred to use the toilet and would usually toilet them or check and change their brief prior to a specified meal service. PSW #115 additionally stated that if resident #001 asked to go earlier in the evening shift the staff would take them.

In an interview, RPN #114 stated resident #001 had an identified level of continence. RPN #114 further stated that staff would toilet resident #001 at the beginning of the identified shift and then ask them if they needed to go to the washroom or the resident would call out when needing to use the washroom. RPN #114 stated there was no toileting schedule for resident #001, but staff would change them when the staff was doing the toileting on the unit.

b. Due to identified noncompliance with O. Reg. 79/10, s. 51. (2) (b). for resident #001, the sample of residents was expanded to include resident #002.

Review of resident #002's health records revealed they were admitted to the home with identified medical diagnoses and health conditions. Review of resident #002's MDS assessment revealed they were dependent on staff for toileting and required two person assistance. The assessment further revealed resident #002 was frequently incontinent and used pads or briefs.

Review of resident #002's current plan of care revealed they required extensive assistance from two staff to transfer for toileting and required assistance for care related to toileting. The care plan indicated that resident #002 required total assistance for brief changes. The care plan further indicated that resident #002 was occasionally incontinent and required assistance from staff for toileting.

In an interview, PSW #119 stated that resident #002 was incontinent and that staff would check and change them. In an interview PSW #122 stated that resident #002 would not let staff know if they needed to be toileted and would be toileted during identified periods throughout the shift. PSW #122 stated they had not been putting resident #002 onto the toilet, but transferring them to bed to change the brief. In an interview PSW #121 stated resident #002 did not go to the toilet, but did it in the brief as they were incontinent and was not always easy to toilet them during the day as the resident exhibited identified responsive behaviours.

In an interview, RPN #114 stated resident #002 was incontinent, but may indicate when they needed to go to the washroom. RPN #114 further stated that resident #002 was checked and changed at the start of the shift and routinely following an identified meal service, but did not have a toileting schedule. In an interview RPN #118 stated they had not noticed staff taking resident #002 to the toilet and that they were mostly incontinent. RPN #118 stated there was no toileting program and the care plan had not been individualized to promote and maintain continence.

In an interview, RMC #105 stated resident #002 had an identified continence status. RMC #105 stated resident #002 did not have a toileting schedule, but team members would toilet them when they got up and before or after meals and if they asked to go. RMC #105 acknowledged that resident #002's plan of care was not individualized to promote and maintain continence.

c. Due to identified noncompliance with O. Reg. 79/10, s. 51. (2) (b). for resident #001, the sample of residents was expanded to include resident #003.

Review of resident #003's health records revealed they were admitted to the home with identified medical diagnoses. Review of resident #003's MDS assessment revealed they required extensive assistance from two staff members for toileting. The assessment further revealed resident #003 was incontinent all or almost all of the time and used pads or briefs.

Review of resident #003's current plan of care revealed they required total assistance from two staff to transfer and one staff member for the process of toileting. The plan of care further revealed resident #003 was incontinent and wore a regular brief to manage incontinence.

In an interview, PSW #121 stated that resident #003 would be changed after an identified meal service as the resident would normally required a change. PSW #121 indicated that staff would usually not toilet resident #003 prior to the arrival of the evening shift. In an interview, PSW #122 stated there was no information in the care plan on when to toilet resident #003, but would do so before and after meals.

In an interview, RPN #118 stated resident #003 was incontinent and required total assistance from staff for toileting. RPN #118 stated staff members would check resident #003 every two to three hours. RPN #118 indicated resident #003 would be checked at identified times as this was the usual routine for all residents. In an interview, RPN #114 stated resident #003 would require toileting assistance daily at an identified time and indicated that this information regarding toileting was not care planned for resident #003.

In an interview, RMC #105 stated resident #003 was incontinent and totally dependent on staff for continence care. RMC #105 further stated resident #003 would be toileted identified times and was unable to communicate when they needed to be toileted. RMC #105 indicated that resident #003's plan of care was not individualized for toileting.

In an interview, Assistant Director of Nursing (ADON) #120 stated that some residents had a toileting routine, and for other residents they would be checked and changed at specified times and before or after meals. ADON #120 further stated that the PSW staff would know the residents and who needed to be toileted at certain times. ADON #120 stated that residents #001, #002 and #003's care plans were not reflective of toileting routines, and acknowledged that residents #001, #002 and #003's care plans had not been individualized to promote and maintain continence.

The severity of this issue was determined to be a level 1 as there was minimum risk to the residents. The scope of the issue was a level 3 as it affected three out of three sampled residents. The home had a level 2 compliance history as there

were previous unrelated non-compliances cited. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Adam Dickey

Service Area Office / Bureau régional de services : Toronto Service Area Office