Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 25, 2016;	2016_449619_0026 (A1)	021329-16	Resident Quality Inspection

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 TANSLEY WOODS
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

Ontario

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SAMANTHA DIPIERO (619) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 21 day of November 2016 (A1)

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

Original report signed by the inspector.

Ontario

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SAMANTHA DIPIERO (619) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 27, 28, 29, 2016, & August 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 2016.

The following inspections were completed concurrently with the Resident Quality Inspection (RQI):

Follow Up Inspections:

023784-15 – follow up to order #001

023785-15 – follow up to order #002

023786-15 - follow up to order #003

Critical Incident Inspections:

026919-15 – Alleged staff to resident abuse

035029-15 – Responsive behaviours

036331-15 – Fall with fracture

003685-16 –Responsive behaviours

004846-16 – Responsive behaviours

007119-16 – Alleged staff to resident abuse

012956-16 – Fall with injury/change in status

020165-16 – Responsive behaviours

Complaint Inspections:

017808-15 – Personal support services

031909-15 – Call bell response

012401-16 – Personal support services

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Assistant General Manager (AGM), the Administrative Assistant, Director of Nursing and Personal Care (DOC), Neighbourhood Co-ordinators (NC), Housekeeping/Laundry Supervisor, Food Services Manager (FSM), Building Operations Supervisor, Registered Dietitian, Social Worker, Kinesiologist, Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Maintenance Workers, Housekeeping staff, Laundry personnel, Residents' Council members, Treasurer of Family Council, residents, and family members.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

15 WN(s)
7 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #002	2015_265526_0012	591
LTCHA, 2007 s. 6. (1)	CO #001	2015_265526_0012	619

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On an identified date in August 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources". Prevailing practices includes using generally accepted widespread practice as the basis for clinical decisions. The companion documents were also prevailing practices and provided necessary guidance in establishing a clinical assessment where bed rails were used. One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who used one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and

while they are asleep). The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails were considered for transferring and bed mobility, discussions needed to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident’s medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed in accordance with the Clinical Guidance document identified above. The Director of Recreation (Lead for bed rail entrapment monitoring) and Neighbourhood Coordinator #205 confirmed that not all of the above required guidelines items were included in the home's "Bed Rail Assessment form".

A) The home's policy, "Bed Entrapment & Bedrail Assessment", revised April 2016, did not include a process by which the resident's sleep patterns, habits and behaviours could be evaluated while sleeping in bed with or without the application of bed rails. The home's policy did not include details as to how the assessment of residents would be conducted or any written procedures for staff guidance other than completion of the "Bed Rail Assessment", which did not include all of the required components of an assessment. Neither the form nor the policy included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period. The Bed Rail Assessment form did not include any questions related to medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, alternatives tried. The policy directed staff to use only the

Bed Rail Assessment form unless 1/2 or full rails were being used, and then an additional assessment form would be completed (The PASD/Restraint Alternatives Assessment). Bedrails that did not have a restraining effect would only be assessed using the Bed Rail Assessment form that did not include all of the required assessment information.

B) Resident #107 was observed in bed with two bedrails raised on an identified date in August 2016. The resident's plan of care stated the resident did not require bed rails. A documented assessment of the resident was not completed prior to applying the bed rails to determine if the resident needed the bed rails, type of rails most appropriate, potential safety risks associated with one or more bed rails while in use by the resident when in bed, etc. The Director of Recreation and Neighbourhood Coordinator #205 confirmed that an assessment of the resident prior to the application of the bed rails had not been completed and the plan of care had not been updated to reflect the use of the bed rails. The Director of Recreation confirmed that the resident had had a decline in condition and bed rails were applied. The bed evaluation (entrapment audit) for their bed was completed; however, an assessment of the resident for bed rail safety had not been completed.

C) Resident #010 had two quarter rails attached to their bed and in the raised position. Staff confirmed the resident had the bed rails in place while they were sleeping or in bed. The resident had a Bed Rail Assessment form completed on an identified date in October 2015, that directed staff to provide beds rails. The resident's plan of care also directed staff to use a specific rail length on the right side and a second specific rail length on the left side of the resident's bed. A documented assessment of the resident and the need for two bed rails or change from the previously identified rail had not been completed. Staff were using the two bed rails without a documented assessment and without updating the resident's plan of care. The Director of Recreation confirmed that an assessment using the home's Bed Rail Assessment Tool and/or Alternatives to PASD / Restraint Assessment had not been completed when there was a change from one 3/4 bed rail and one quarter bed rail, to two quarter bed rails.

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee failed to ensure that the resident was provided the opportunity to participate fully in the development and implementation of their plan of care.

During stage one of the Resident Quality Inspection (RQI) resident #130 stated that they were not invited to participate in their care conference and was not involved in decisions about their care. The resident stated they would like to be

more involved in decisions about their care. On an identified date in August 2016, the resident remembered speaking to the Inspector about care conferences on an identified date in July 2016, and again confirmed that they had not been invited to attend a care conference held on an identified date in May 2016. Documentation from the care conference held on an identified date in May 2016, confirmed the resident was not in attendance at the conference; only the resident's POA attended the meeting. Registered staff #204 confirmed the resident was capable of making some decisions about their care and could voice their preferences to staff.

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #132 had a plan of care on admission on an identified date in April 2016, that required specialized snacks; however, the items had not been entered into the home's computerized system and the resident was not receiving the items since they were added to the plan of care on admission. The Food Services Manager (FSM) confirmed that the items had not been added to the computerized system and were not being offered to the resident. The resident had a significant weight loss since admission in a three month period.

B) Resident #123 had a plan of care that directed staff to provide a specialized snack in the afternoon and evening. The Food Services Manager confirmed that the specialized snack had not been added to the computer and labels that directed staff to add the specialized snack to the snack cart were not in place. The resident had not been receiving the specialized snack at the afternoon and evening snack pass. Documentation on the Nutrition and Hydration flow sheets reflected the resident took an afternoon snack on 5/31 days and an evening snack on 14/31 days in July 2016. The resident has had slow weight loss since admission to the home in February 2016.

C) Resident #050 reported on an identified date in March 2016, to their family member that PSW #244 had physically abused them during the night shift. A review of resident #050's written plan of care indicated that the resident required assistance from two PSW staff and that the resident had preferred care givers. A review of the investigation notes revealed a written statement provided by staff #244, whom resident #050 alleged physically abused them. Staff #244 indicated that they provided care to the resident without the assistance of another staff, as the other PSW had stepped away to assist with another resident. The staff member stated they proceeded to provide continence care independently. The staff member

did not report the incident to the nurse in charge, but did notify the Neighbourhood Coordinator (NC), staff #205, by leaving a message on their voicemail at the end of their night shift. In an interview, staff #205 stated that they interviewed staff #244 who confirmed they did not follow the resident's written plan of care which stated the resident should be cared for by two staff at all times. Staff #244 stated that they knew of the instructions in the written plan of care; however, assistance was not available and they did not want to leave resident #050 soiled. Staff #205 confirmed that staff #244 did not provide care to the resident as specified in the plan.

D) Resident #100 was identified as having multiple falls in six months and was identified as a medium risk for falls. A review of the resident's written plan of care indicated that the as part of the falls prevention strategy the resident would require the use of a medical garment protectors worn daily to reduce the risk of injury if a fall occurred. Family members stated in an interview that the resident owned multiple pairs of said medical garments but that one pair was missing and that the others were not being applied. Interview with PSW #225 confirmed that the resident's pair of medical garments were missing and that the remaining pairs were not being applied consistently because they were soiled. Registered staff #204 confirmed that the resident required medical garments as part of their falls prevention interventions. An interview with the DOC confirmed that care was not provided as per the plan of care.

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #002 was hospitalized on an identified date in December 2015, as a result of an injury due to a fall. The resident returned to the home after receiving treatment in hospital in December 2015.

A) The home's policy called "Re-Admission", number 01-10, last revised January 2013, directed the Resident Assessment Instrument (RAI) Co-ordinator to determine if there was a significant change, and if so, a new Minimum Data Set (MDS) assessment would be initiated. In addition, the policy directed staff to review and update the resident's written plan of care. The clinical record was reviewed and it was identified that no MDS assessment was initiated, and the written plan of care was not reviewed or revised when the resident returned from the hospital. The RAI Co-ordinator was interviewed and confirmed that they were expected to initiate

a new MDS assessment when the resident had a change of condition and that this was not done. Registered staff #217 and #235 were interviewed and confirmed that they were unable to locate the revised written plan of care from December 2015, when the resident returned to the home. The registered staff #217 also confirmed that they were unsure whether they reviewed and revised the written plan of care when the resident had a change in condition.

B) The home's policy called "Fall Prevention & Management [LTC]", number 04-33, and revised February 2013, directed registered staff to conduct a Fall Risk Assessment for each resident with any change in condition, for potential risk for falls in order to take a preventative approach. The interventions would then be based on the individual risk factors identified in the assessment and would be developed and implemented for the resident. Resident #002's clinical record was reviewed and there was no Fall Risk
Assessment completed for the resident when they returned from the hospital on an identified date in December 2015, after they had been hospitalized and had a significant change, which occurred as a result of a fall in the home on an identified date in December 2015. The Falls Risk Assessment was not conducted until an identified date in January 2016, which was more than one month after the resident had a significant change in condition. The DOC and registered staff #235 were interviewed and confirmed that a Fall Risk Assessment should have been completed for the resident when he returned to the home with a significant change in condition and this was not done. The home failed to ensure resident #002 was reassessed for risk of falls and the plan of care was reviewed and revised when their care needs changed.

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Resident #061 required the use of a walker for ambulation due to a poor shuffling gait. A review of the resident’s health record indicated that resident #061 had two previous falls, the last one due to an attempt at self-transferring to the bathroom during the night without the use of their walker. On an identified date in March 2016, resident #061 fell while attempting to self-transfer to the bathroom without the use of their walker, resulting in an injury which required transfer to hospital for treatment. The resident’s falls prevention care plan dated February 2016 stated that the resident required monitoring of medication, and non-slip footwear, and

encouragement to use the call bell to ask for assistance from staff when required. This care plan was updated after the resident's return from hospital to include several additional falls interventions to reduce the risk of injury. Interview with PSW #225 indicated that prior to the resident's fall with injury the resident had limited insight into their mobility needs and frequently had to be reminded to use their mobility device when ambulating, and to use their call bell. An interview with RN #210 indicated that the resident received multiple medications that negatively impacted the resident's gait and that cognitive impairment was a factor in the two previous falls and confirmed that the resident's care plan was not updated to include new strategies and interventions prior to the fall in March 2016. Interview with Kinesiologist confirmed that the resident's falls prevention strategies were not revised after the resident's fall in February 2016, and that the falls prevention care plan was not effective. An interview with the DOC confirmed that the resident's plan of care as it related to falls prevention was not revised when the care set out in the plan had not been effective.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Critical incident report submitted by the home on an identified date in March 2016, related to an allegation of abuse by PSW #244 to resident #050 that occurred on an identified date in March 2016, whereby the resident alleged that the staff member physically abused them during care. According to the report submitted by the home, in an interview with staff #205, the resident alleged that staff #244 physically abused them. In an interview, resident #050 declined discussion of the above mentioned incident, stating they could not recall the details, and confirmed that staff #244 no longer provided their care. A review of the resident's written plan of care indicated that the resident required two PSW staff for the provision of care and that the resident had preferred care givers. A review of the investigation notes revealed a written statement provided by PSW #244, whom resident #050 alleged physically abused them. PSW #244 indicated that they provided care to the resident without the assistance of another staff the night of the incident, as PSW #245 had stepped away to assist with another resident. The staff member stated they proceeded to provide care independently while the resident continued to protest during the care. The staff member did not report the incident to the nurse in charge that shift, but did notify the neighbourhood coordinator, staff #205, by leaving a message on their voicemail at the end of their shift. The home initiated an investigation into the allegation the next day. The investigation notes included the statement of PSW #245 who assisted PSW #244 to care for the resident later that shift, and confirmed that PSW #244 continued to provide care to the resident while the resident actively refused care. Staff #205 as per their statement in the investigation notes, indicated that on assessment of the resident the morning following the incident, they found injuries on the resident but were unable to determine if these injuries were obtained during the provision of care the previous night; however, a nursing assessment of the resident post-incident could not be produced. PSW #244 stated they knew of the instructions in the written plan of care; however, assistance was not available at the time so they continued to provide the care despite the resident's request for them to stop, as they did not want to leave the resident soiled.

Under the Ontario Regulation 79/10 emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or

remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident". PSW #244 ignored the resident and continued to provide care despite the resident refusing care by making verbal and physical indications of refusals. The resident was noted to be refusing care and PSW #224 continued to provide care. As per the resident, they felt significantly distraught after the interaction with PSW #244. The licensee did not protect resident #050 from emotional abuse by PSW #244 and #245.

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

The home's policy, "Nutrition and Hydration", approved April 2014, directed staff to report to the oncoming RPN/RN any resident who had a fluid intake less than their estimated fluid requirements so that interventions could be initiated. The RPN/RN would then assess signs and symptoms of dehydration using the Dehydration Risk Assessment Tool. If a resident exhibited signs and symptoms of dehydration (as documented in the Dehydration risk assessment tool) staff were to ensure the request for Nutrition Consultation form had been initiated for the Registered Dieititan to assess. The policy directed staff to complete the Request for Nutrition Consultation form when a resident had a fluid intake of less than 1000 mL or per individual fluid requirement as per the plan of care for three consecutive days and there is at least one sign or symptom of dehydration present. If a resident consumed less than 1000 mL of fluid for five consecutive days with one or more signs or symptoms of dehydration present and the resident has not been assessed by the RD, then staff were to notify the Physician.

The home's policy was not complied with for resident #132 when they had continued poor hydration. The resident had a plan of care that identified a minimum fluid requirement daily. Documentation on the resident's Nutrition and Hydration Flow Sheets reflected an average fluid intake that was less than the daily fluid requirement for the month of July 2016. The flow sheets reflected the resident consumed less than their daily fluid requirement for at least three consecutive days in May 2016, June 2016, and July 2016. Registered staff #211 and NC #205 confirmed that staff were not using the Dehydration Risk Assessment Tool to complete hydration assessments. The resident's clinical health record did not contain any Dehydration Risk Assessment Tools to assess if the resident had any signs or symptoms of dehydration and there were no referrals to the Registered Dietitian (RD) related to the ongoing poor hydration. The RD confirmed that she had not received any referrals related to poor hydration for the resident.

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and implemented in accordance with all applicable requirements under the Act. Regulation 51(2)(a) requires that every 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.

The home's policy, "Continence", dated January 2013, directed staff to complete a continence assessment using the RAI-MDS tool in combination with a resident specific assessment (assessment tool on Gold Care - Admission & Quarterly Bowel and Bladder Assessment), a detailed three day Voiding and Bowel Elimination Record and the RAI-MDS seven day observation period on admission to the home. The policy directed staff to complete only the continence assessment tool with a care plan update quarterly and as needed. The policy did not address what staff were to complete when there were changes in the resident's level of continence. The "Admission & Quarterly Bowel and Bladder Assessment" that staff were completing quarterly and to capture changes to resident's level of incontinence did not include all of the required areas that are outlined in regulation 51(2)(a). The assessment did not include patterns, type of incontinence, and potential to restore function with specific interventions. Documentation was not available to support that the tool being used was a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

The Continence policy also did not include all the required components of regulation 51(1). The policy did not include treatments and interventions to promote continence, treatments and interventions to prevent constipation, including nutrition and hydration protocols, and toileting programs, including protocols for bowel management.

3. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system was complied with.

Long Term Care Homes Act, 2007, Regulation 79/10, section 68(2)(e)(ii) requires the home to have a weight monitoring system to measure and record with respect to each resident, their height upon admission and annually thereafter. The home's policy, "Weight & Height Monitoring", dated August 2015, also directed staff to measure residents' heights on admission and annually and then enter the heights into the home's computer software program. During stage one of this inspection, many heights were either not recorded in the home's Gold Care documentation system or were not measured and recorded since admission (sometimes several years prior) in the resident's paper chart or both.

A) Not all residents had their heights measured on admission. Documentation for residents #130, #035, and #100, reflected the admission heights were not measured on admission but taken from Community Care Access Centre (CCAC) documentation.

B) Not all residents had their heights measured and recorded annually. Residents #067, #066, #010, #018, and #103, had their height recorded on admission (prior to 2015); however, did not have an annual height measured or recorded.

C) Not all residents had a height recorded in the home's Gold Care computer system. Residents #066, #010, #130, #035, #123, #018, #011, #132, #103, and #045 did not have a height available in the Gold Care computer system.
NC #205 confirmed that numerous admission and annual heights were missing from the Gold Care computer system and had not been entered by staff.
Registered staff #204 stated that heights were only recorded on admission and not annually.

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

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained procedures for investigating and responding to alleged or suspected abuse and neglect of residents.

A review of the home's policy titled "Prevention of Abuse in Long Term Care", approved July 2015, stated:
"Procedure – Team Member to Resident – Team Leader and/Charge Nurse
1. If the abuse was witnessed, immediately separate the Resident from the alleged offender. Call the charge nurse for assistance when there is a risk of harm to yourself or others.
2. The charge nurse will immediately contact the NC or the Leadership Team Member on-call who will then contact the Police and the POA/SDM for all residents involved as soon as the situation/neighbourhood is safe and secure.

3. Have a team member who is close to the Resident stay and provide comfort and reassurance to the resident until they receive further instructions form the Team Leader and/or Charge Nurse.
4. Any Team Member with reasonable grounds to suspect that any type of abuse or neglect has occurred, or may occur, must immediately report
5. After ensuring that all parties are safe and secure, and all parties have been notified, the Charge Nurse and/or Team Leaders will initiate an internal investigation and complete an Incident Report form and Investigation Tool before leaving the village.
6. To the best of your ability do not disturb any evidence.
7. Document in the current computer software system all the following: what was the incident, what you did about the incident, who you identified about the incident, your assessment and findings, the outcome."

This section of the policy did not include a procedure for when the abuse was "not witnessed" but was an "allegation or suspicion" as per the legislation. The policy does not include that an assessment of the resident should be completed ie. head-to-toe assessment, nor did it include instructions on how to deal with the staff member accused of abusing the resident ie. removal of the staff from the resident's care pending investigation. This section of the policy also did not provide the procedure to notify any authority of an "alleged" abuse of a resident ie. Police, Medical Director.

"Procedure – Team Member to Resident - General Manager/Director of Care/Neighbourhood Co-ordinator/Designate/On-call Manager:
1. Once notified of a suspected, alleged, or witnessed abuse, confirm that the resident is safe and reassurance is being provided. If sexual or physical abuse occurred, call the medical Director for the village and request a Medical Report with an opinion as to the probable cause of the injury.
2. Continue to provide support to the Resident by a Team Member who has a good relationship with the resident.
3. If a criminal offence has taken place (eg. sexual abuse, physical abuse, theft), call the police immediately if not already done. Otherwise confer with the VP of Operations as to whether or not Police should be contacted.
4. Notify the following immediately if there is a physical injury, pain, and/or distress that is harmful to the health and well-being of a Resident.

This statement did not include a procedure for steps to take in the event of an

"allegation or suspicion" of "sexual or physical abuse" as per the legislation, ie. conducting a head-to-toe assessment, who to notify and when, for example the police and/or Medical Director.

The home's policy to promote zero tolerance of abuse and neglect of residents did not contain procedures and interventions to assist and support residents who have been allegedly abused, nor did it contain procedures and interventions to deal with persons who have allegedly abused residents, as appropriate.

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 with s. 20. (2) where at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (a) shall provide that abuse and neglect are not to be tolerated; (b) shall clearly set out what constitutes abuse and neglect; (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; (d) shall contain an explanation of the duty under section 24 to make mandatory reports; (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; (f) shall set out the consequences for those who abuse or neglect residents; (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and (h) shall deal with any additional matters as may be provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee failed to ensure that the results of the abuse or neglect investigation and every action taken were reported to the Director.

A critical incident report was submitted by the home on an identified date in March 2016, related to an allegation of abuse by PSW #238 to resident #050 that occurred on an identified date in March 2016 whereby the resident alleged that the staff member physically abused them during care.

In an interview, staff #205 stated every abuse investigation is initiated by the Neighbourhood Coordinator, Director of Care (DOC) or the Assistant General Manager (AGM). It was then the responsibility of the person initiating the investigation, if not the DOC or AGM, to complete the investigation and provide the information to either the DOC, the Director of Recreation or the AGM (the only persons with access to the system), who then take the information, update the critical incident report, and submit it to the Director with the results of the investigation by way of an amendment to the form. After searching the resident's health record, staff #205 confirmed that the results and every action taken of the above mentioned investigation had not been documented, nor reported to the Director.
In an interview, the AGM stated that they took their own notes of interviews they conducted during the investigation, staff #205 also took notes, and the former DOC took notes which could not be located. The AGM confirmed the results and every action taken related to the above mentioned abuse investigation had not been documented by way of an amendment to the critical incident report and had not been submitted to the Director.

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 with s. 23. (2) where the licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) During an interview, resident #045 stated on two occasions that they were not invited to attend their care conference. Documentation from the resident's care conference held in May 2016, identified the resident was not present during the conference; only the resident's family member and their SDM were in attendance at the meeting. During interview in August 2016, NC #205 stated that the resident had been invited; however, stated they did not want to attend. NC #205 stated that the resident's son asked for the resident's feedback prior to the care conference. Documentation was not available to support that the resident was invited to their care conference but declined to come.

B) Resident #018 had a plan of care that required staff to document toileting on the

flow sheet located in the resident's washroom. The resident's plan of care identified the resident was to be toileted every two hours. Documentation on the flow sheet located in the resident's washroom reflected the resident was not toileted on an identified date in August 2016, and on a second date in August 2016, that the resident was toileted. During interview, PSW #130 stated that the resident was being toileted every two hours but staff were not always signing on the documentation form as per the resident's plan of care.

C) Resident #002 was hospitalized on an identified date in December 2015, as a result of an injury due to a fall. The resident returned to the home after hospitalization in December 2015. The clinical record was reviewed and the LTC Inspector was unable to find any documented falls prevention interventions for the resident. PSW #218, PSW #222 and registered staff #217 were interviewed and were unable to identify what falls prevention interventions were in place when the resident returned from the hospital. The registered staff confirmed that they were expected to document the falls prevention interventions on the written plan of care for resident #002 based on the falls risk assessment and was unsure if this was done. Registered staff #235 was able to identify that there was a review of the falls prevention and management on the resident's written plan of care on an identified date in December 2015, but was unable to produce any documentation to support that falls prevention interventions were in place for resident #002.
The "Personal Care Observation and Monitoring Form" used by the PSWs for the documentation of resident care was reviewed for resident #002. The LTC Inspector identified that from December 2015, to January 2016, there was no documentation or inconsistent documentation by the PSWs related to the resident's falls prevention interventions. PSW #218 and PSW #222 confirmed they were expected to document on each shift that the falls prevention interventions were in place. The DOC was interviewed and reviewed the documentation by the PSWs, and confirmed that the PSWs were expected to document on each shift that resident #002's falls interventions were in place. The home failed to ensure that resident #002 had falls prevention interventions documented in the written plan of care, that there were documented responses to those interventions, and that the PSWs documented on each shift that the falls interventions were in place.

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 with r. 30. (2) where the licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee failed to ensure that resident #132 was assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated when they had ongoing weight loss due to poor food and fluid intake.

Resident #132 had a significant weight loss over a three month period after admission between April 2016 and August 2016. Nutrition and Hydration Flow sheets reflected poor intake at meals and snack refusals and poor hydration during the three months. The resident had a plan of care that required a minimum of volume of fluids per day. Documentation on the "Nutrition and Hydration Flow Sheets" reflected an average fluid intake that did not meet their fluids requirements. A referral to the Registered Dietitian (RD) for assessment of the ongoing poor intake and hydration did not occur and the resident had not been

reviewed by the RD since an identified date in June 2016. An interdisciplinary assessment of the resident in relation to the ongoing poor intake, poor hydration, and weight loss did not occur when the concerns continued.

On admission, the RD initiated special snacks daily. The afternoon snack pass was observed on an identified date in August 2016, and the specialized snack was not available on the snack cart. The Nutrition Services Manager confirmed that the specialized snacks had not been entered into the computer system and were not being provided to the resident since admission. Documentation on the flow sheets reflected the resident took a food snack on 18/276 snacks during the three month period. A multidisciplinary assessment of the resident's snack intake and referral to the Registered Dietitian for re-evaluation of the snack intervention had not been completed.

The resident also had an individualized menu for meals that was selected by the resident's Substitute Decision Maker (SDM); however, the menu was not adequate to meet the resident's nutritional and fluid needs. Personal Care Aide #212 stated that the resident had ongoing poor intake and they did not feel that the resident's planned menu was adequate. Communication back to the Registered Dietitian for re-evaluation of the individualized menu did not occur when staff noted the menu was insufficient.

The resident had a plan of care goal for the minimization of weight loss. The licensee failed to ensure that the resident was assessed using an interdisciplinary approach and that actions were taken and outcomes were evaluated for resident #132 when they had ongoing weight loss due to poor food and fluid intake.

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 with r. 69 where every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #9: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee failed to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any

response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

The LTC Inspector reviewed the home's Complaint log for 2015 and 2016. Four email complaints were identified that did not include the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; and/or the date on which the response was provided to the complainant and a description of the response.

1) The home received an email complaint on an identified date in August 2015, from the Substitute Decision Maker (SDM) for a resident in the home regarding their concerns with their family member's care and services. The home acknowledged receipt of the email the following day and initiated their investigation. The home's "Resident/Family Concerns Response Form", identified the date the concern was received was on an identified date in August 2015, which was six days later. Several emails were shared between the home and the complainant to identify further details to assist with the investigation, and at some point the home contacted the complainant to discuss their policy and procedures and to discuss the concern related to a change in staffing. There was no date of when that discussion took place, there was no identification whether follow-up was required and by whom, and there was no final resolution or date documented of the final resolution.

2) The home received a complaint from an SDM on an identified date in October 2015. The home responded via email acknowledging receipt of the email and requesting time to investigate. There was no further description of the concerns, and no information provided to the SDM as to what measures were implemented until the following morning, after the home received another email from the complainant outlining their significant concerns related to their family member's safety. The "Resident/Family Concerns Response Form" was incomplete and it did not identify the accurate date the concern was received and the telephone information of the complainant. In addition, a description of the concerns was not documented and the documentation referred the reader to refer to the email, which also did not describe the concerns. The complaint was resolved and interventions were implemented to the satisfaction of the SDM; however, there was no date when the complaint was resolved and there was no documentation that the Assistant General Manager or General Manager received and reviewed the complaint.

3) The SDM of a resident contacted the home by email on an identified date in March 2016, and identified their concerns with their family member's care. The home identified that the final resolution occurred on an identified date in March 2016, which was 15 days after the complaint was received. In the same complaint, there was follow-up documented, which identified that the DOC and the Kinesiologist were in contact with the complainant regarding the implemented interventions and updates; however there was no date as to when that response was provided to the complainant, no time frame identified of the actions that were being taken to resolve their concerns, and no documentation of the response from the complainant when contacted by the DOC and Kinesiologist.The resolution identified that updates would be ongoing regarding the resident's wounds and implementation of interventions were done, but there were no time frames identified, to ensure the complainant knew when to expect the updates and/or changes to the plan of care.

4) The home received an email complaint on an identified date in May 2016, regarding a resident's finances. There was no telephone number documented on the home's "Resident/Family Concerns Response Form". The follow-up occurred on an identified date in May 2016, with final resolution on a third identified date in May 2016, which was 13 days after the complaint was received. The SDM was dissatisfied with the follow-up actions taken by the home. The home's policy called "Resident/Family Concerns", number 11-21, revised February 2016, directed staff to have the SDM speak directly with the Neighbourhood Coordinator, and if the SDM was still not satisfied, they would be encouraged to refer the matter to the General Manager, which will be responded to in writing within 10 days. There was no documentation in the home's response whether any further referral was made to the NC or the GM for resolution of the complainants concerns, and/or any further follow-up actions, time frames, and documented responses from the complainant. The home failed to ensure that that a documented record was kept in the home of all complaints that included the elements as outlined and required in Regulation 79/10, s. 101 (2).

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with r. 101 (2) where the licensee shall ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #10: 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 :

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On an identified date in July 2016 during the initial tour of the home a total of three home areas were observed to have unlabelled used personal hygiene products in the Spa Shower and Spa Tub rooms. In the Appleby home area two silver coloured nail clippers in a clear box labeled "extra, clean" were identified as soiled, as well as two unlabeled used hair brushes and two unlabeled used deodorants. On the Oaklands home area an unlabeled, soiled manicure stick was identified as well as two unlabeled soiled nail clippers, two unlabeled razors, one unlabeled hair brush, two used and unlabelled nail clippers and one pair of soiled metal cuticle trimmers. On the Nelson area of the home two unlabeled and soiled electric shavers were identified as well as one unlabelled toothbrush, two used and unlabelled nail clippers, and one pair of soiled metal cuticle trimmers. Housekeeping and PSW staff confirmed that these items should be labeled in accordance with the home's infection prevention and control policy. Not all staff participated in the infection prevention and control program in relation to the storage and use of personal care items.

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 with r. 229 (4) where the licensee shall ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #11: 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

Resident #121 wore dentures daily and had a long standing history, prior to admission, of not removing their dentures overnight or soaking their dentures. The resident was now dependent on staff for oral hygiene. The resident's plan of care did not reflect that the resident wore dentures or that they required a specific routine for caring for the dentures. Registered staff #204 and PSW #220 were aware of the resident's routine; however, the resident's plan of care did not include this information. Registered staff #204 stated they had multiple verbal discussions with the resident's SDM in relation to oral hygiene; however, documentation was not available to support what care was to be provided in relation to the resident's specific oral care needs. Registered staff #204 confirmed that the plan of care did not provide specific direction related to the resident's oral hygiene routine and should have as the resident's care requirements varied from the routine for most residents.

2. The licensee failed to ensure that the registered dietitian who was a member of the staff of the home assessed a resident's nutritional status, including height, weight and any risks related to nutrition care, and hydration status, and any risks related to hydration.

Nutrition and Hydration Flow sheets for resident #132 reflected poor intake at meals and snack refusals and poor hydration over a three month period after admission between April 2016, and August 2016. The resident had a plan of care that required a minimum volume of fluids per day. Documentation on the "Nutrition and Hydration Flow Sheets" reflected an average fluid intake for May and June 2016 that was less than their daily fluids requirements. The home's policy, "Nutrition and Hydration", approved April 2014, identified the home's typical menu offered 1875 mL per day. A plan was not in place to ensure that the resident was offered sufficient fluids above the menu standard of 1875 mL per day to meet their minimum hydration requirement fluids daily. The resident was reviewed by the RD on two identified dates in May and June 2016, and on an identified date in May 2016, the Registered Dietitian stated the resident was consuming less than their daily fluid requirements. The resident's plan of care was not revised to include strategies to improve the resident's hydration up to their target servings of fluids per day. Documentation between the Nutrition and Hydration flow sheets and the RD assessment notes was not consistent in the quantity of fluids the resident was consuming.

On admission, the Registered Dietitian initiated special snacks. The evening snack had been entered into the computer system and a specialized label was available to direct the staff to prepare the snack for the snack cart. The specialized snacks for the afternoon and evening had not been entered into the computer system and no special labels were available to direct staff in the preparation of the items. The morning and afternoon snacks were not being prepared and sent up on the snack carts. The afternoon snack pass was observed on an identified date in August 2016, and the specialized snack was not available on the snack cart. The Nutrition Services Manager confirmed that the specialized snacks had not been entered into the computer system and were not being provided to the resident since admission. Documentation on the Nutrition and Hydration flow sheets reflected the resident took a food snack on 18/276 snacks during the three month period. An evaluation of the effectiveness of the nutrition strategy (specialized snacks) was not completed at the May and June 2016, RD assessments and it was not identified that the resident was not receiving the interventions. Nutrition strategies related to weight and hydration were not revised at that time.

The resident also had an individualized menu for meals that was selected by the resident's SDM; however, the menu was not adequate to meet the resident's nutritional and fluid needs, often no entree or protein item was included in the

selections. The Nutrition Manager confirmed that when the individualized menu did not reflect an entree staff were directed to provide only the items identified on the menu. During interview, the RD confirmed the family preferred the resident to eat from an individualized menu. The individualized menu that the SDM used for food choices was a regular menu versus a therapeutic menu. The Registered Dietitian confirmed that the resident's menu had not been reviewed for nutritional adequacy prior to implementation.

The resident was reviewed by the Registered Dietitian on two identified dates in May and June 2016; however, there was no evaluation of the menu or consumption of the specialized snacks and the resident's plan of care was not revised to address the continued weight loss or poor food and fluid intake, stating that the family was not concerned about these issues. The resident had a plan of care goal for the minimization of weight loss. Resident #132 had a significant weight loss over a three month period after admission.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of their choice.

During stage one of the inspection, resident #130 stated they preferred a tub bath; however, were always given a shower. Documentation on the "Bath Preference" form in the resident's clinical health record stated the resident loved baths and preferred two baths per week. Documentation on the posted bathing schedule that directed staff on choice of bath or shower, directed staff to provide a shower on one evenings and a tub bath on day. Documentation on the flow sheets for April to August 2016, reflected that the resident received showers and not tub baths as per the resident's stated and documented preference. On an identified date in August 2016, PSW #216 stated the resident was receiving a shower as the shower room was closer to the resident's room but they would ask the resident their preference that evening. On a second identified date in August 2016, the resident told the Inspector they had been asked their preference of bathing the previous evening were provided a tub bath.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #100 required supervision and encouragement during meals. An interview with a family member indicated that the resident was moved to a new table due to responsive behaviours during meal times while seated at the table; the family member stated that the home did this in relation to infection prevention control concerns. A review of the resident's progress notes indicated that on an identified date in May 2016, the resident was moved to a different table because of ongoing behaviours during meal times; it noted that this behaviour was not new and had not been previously addressed. Interview with PSW #225 indicated that the resident would exhibit responsive behaviours towards table mates and that registered staff were aware for some time. Interview with registered staff # 204 confirmed that the resident's behaviour had been ongoing and that assessments and interventions were initiated after the resident was moved to another table, despite the resident displaying meal related responsive behaviours on several previous occasions. Interview with the DOC confirmed that no actions were taken to respond to the needs of the resident when displaying responsive behaviours during meal times in the dining room.

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

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Resident #002 had a fall on an identified date in December 2015, and the resident was transferred to the hospital on the same day. The home confirmed on the identified date that the resident had an injury that required intervention. The Assistant General Manager (AGM) was interviewed and confirmed that they failed to report this incident to the Director until an identified date in December 2015; seven days after the significant change in the resident's health condition and for which they required hospitalization. The AGM and DOC confirmed that they were expected to notify the Director within one business day and this was not done.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

The licensee failed to ensure that a Personal Assistive Service Device (PASD) used under section 33 of the Act was well maintained.

Resident #053 required the use of a wheelchair for mobility as well as a PASD at identified times.On two identified dates in July 2016, and an identified date in August 2016, Inspector noted that one of the arm rests on the resident's mobility device was damaged. PSW #224 stated that it was damaged by the PASD that is installed and removed multiple times daily, and indicated that the arm rest had been damaged for approximately one month. Registered staff #226 indicated that staff are to make written referrals to the contracted mobility services company for repairs, and indicated that no repair request had been submitted by staff on the resident’s behalf. Interview with Kinesiologist confirmed that a referral for repair to the resident's arm rest was received on an identified date in August 2016, a total of nine days after it was initially observed by inspector. Interview with DOC confirmed that staff are responsible for submitting mobility equipment repair referrals as soon as any damage or defect is noted, and confirmed that this was not completed in timely fashion.

Issued on this 21 day of November 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SAMANTHA DIPIERO (619) - (A1)

Inspection No. / No de l'inspection : 2016_449619_0026 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 021329-16 (A1)

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

Report Date(s) / Date(s) du Rapport : Oct 25, 2016;(A1)

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 TANSLEY WOODS
4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : JO-ANNA GURD

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To 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)

Linked to Existing Order / Lien vers ordre existant: 2015_265526_0012, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing "Bed Rail Risk Assessment " form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include:

A) Questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns

of sleep, behaviours and other relevant factors prior to the application of any bed rails; and

B) The alternatives that were trialled prior to the application of one or more bed rails and document whether the alternatives were effective during the specified period of time; and

C) include the names of the interdisciplinary team members who participated in
evaluating the resident; and

D) Provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are
a safe alternative for the resident being assessed.

2. An interdisciplinary team shall assess all residents who use one or more bed
rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards.

4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Bed Rails" policy and associated forms and procedures to include all of the above noted requirements and any additional relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals,

Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

Grounds / Motifs :

1. Judgement Matrix
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Pattern
- Compliance History: Despite Ministry of Health (MOH) action, non-compliance (NC) continues with original area of NC.
This finding was previously issued as a Compliance Order (CO) in 2015.

2. The licensee failed to ensure that where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On an identified date in August 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources". Prevailing practices includes using generally accepted widespread practice as the basis for clinical decisions. The companion documents were also prevailing practices and provided necessary guidance in establishing a clinical assessment where bed rails were used. One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who used one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasized the need to document clearly whether alternative

interventions were trialled if bed rails were being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails were considered for transferring and bed mobility, discussions needed to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed in accordance with the Clinical Guidance document identified above. The Director of Recreation (Lead for bed rail entrapment monitoring) and Neighbourhood Coordinator #205 confirmed that not all of the above required guidelines items were included in the home's "Bed Rail Assessment form".

A) The home's policy, "Bed Entrapment & Bedrail Assessment", revised April 2016, did not include a process by which the resident's sleep patterns, habits and behaviours could be evaluated while sleeping in bed with or without the application of bed rails. The home's policy did not include details as to how the assessment of residents would be conducted or any written procedures for staff guidance other than completion of the "Bed Rail Assessment", which did not include all of the required components of an assessment. Neither the form nor the policy included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period. The Bed Rail Assessment form did not include any questions related to medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, alternatives tried. The policy directed staff to use only the Bed Rail Assessment form unless 1/2 or full rails were being used, and then an additional assessment form would be completed (The PASD/Restraint Alternatives Assessment). Bedrails that

did not have a restraining effect would only be assessed using the Bed Rail Assessment form that did not include all of the required assessment information.

B) Resident #107 was observed in bed with two bedrails raised on an identified date in August 2016. The resident's plan of care stated the resident did not require bed rails. A documented assessment of the resident was not completed prior to applying the bed rails to determine if the resident needed the bed rails, type of rails most appropriate, potential safety risks associated with one or more bed rails while in use by the resident when in bed, etc. The Director of Recreation and Neighbourhood Coordinator #205 confirmed that an assessment of the resident prior to the application of the bed rails had not been completed and the plan of care had not been updated to reflect the use of the bed rails. The Director of Recreation confirmed that the resident had had a decline in condition and bed rails were applied. The bed evaluation (entrapment audit) for their bed was completed; however, an assessment of the resident for bed rail safety had not been completed.

C) Resident #010 had two quarter rails attached to their bed and in the raised position. Staff confirmed the resident had the bed rails in place while they were sleeping or in bed. The resident had a Bed Rail Assessment form completed on an identified date in October 2015, that directed staff to provide beds rails. The resident's plan of care also directed staff to use a specific rail length on the right side and a second specific rail length on the left side of the resident's bed. A documented assessment of the resident and the need for two bed rails or change from the previously identified rail had not been completed. Staff were using the two bed rails without a documented assessment and without updating the resident's plan of care. The Director of Recreation confirmed that an assessment using the home's Bed Rail Assessment Tool and/or Alternatives to PASD / Restraint Assessment had not been completed when there was a change from one 3/4 bed rail and one quarter bed rail, to two quarter bed rails. (107)

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

Jan 30, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

(A1)
The licensee shall:

1) Prepare, submit, and implement a plan for achieving compliance to ensure that registered staff complete ongoing assessments, reassessments and revisions to the plan of care as required for residents when there is a change in their medical condition, and when the care set out in the plan has not been effective, including but not limited to residents #002, and #061, in relation to falls prevention strategies.

2) Review all residents identified as high risk for falls to ensure that appropriate falls prevention interventions and strategies are in place according to the resident's needs. Audit and revise as necessary all care plans to ensure that the care plans reflect the strategies in place.

3) Ensure that all registered staff in the home receive training related to updating resident plans of care.

The plan shall be emailed to Samantha.DiPiero@ontario.ca by November 30, 2016.

Grounds / Motifs :

1. Judgement Matrix
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Isolated
- Compliance History: Despite Ministry of Health (MOH) action, non-compliance (NC) continues with original area of NC.
S. 6(10) was previously issued as a Voluntary Plan of Correction (VPC) in 2014 and issued as a Compliance Order (CO) in 2015

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #132 had a plan of care on admission on an identified date in April 2016, that required specialized snacks; however, the items had not been entered into the home's computerized system and the resident was not receiving the items since they were added to the plan of care on admission. The Food Services Manager (FSM)

confirmed that the items had not been added to the computerized system and were not being offered to the resident. The resident had a significant weight loss since admission in a three month period.

B) Resident #123 had a plan of care that directed staff to provide a specialized snack in the afternoon and evening. The Food Services Manager confirmed that the specialized snack had not been added to the computer and labels that directed staff to add the specialized snack to the snack cart were not in place. The resident had not been receiving the specialized snack at the afternoon and evening snack pass. Documentation on the Nutrition and Hydration flow sheets reflected the resident took an afternoon snack on 5/31 days and an evening snack on 14/31 days in July 2016. The resident has had slow weight loss since admission to the home in February 2016 .

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Resident #061 required the use of a walker for ambulation due to a poor, shuffling gait. A review of the resident's health record indicated that resident #061 had two previous falls in December 2015, and February 2016, the last one due to an attempt at self-transferring to the bathroom during the night without the use of their walker. On an identified date in March 2016, at 0555 hours, resident #061 fell while attempting to self-transfer to the bathroom without the use of their walker,resulting in an injury which required transfer to hospital for treatment. The resident's falls prevention care plan dated February 2016 stated that the resident required monitoring of medication, and non-slip footwear, and encouragement to use the call bell to ask for assistance from staff when required. This care plan was updated in May 2016, after the resident's return from hospital to include a bed alarm, a high-low bed, and a falls mat to reduce the risk of injury. Interview with PSW #225 indicated that prior to the resident's fall with injury the resident had limited insight into their mobility needs and frequently had to be reminded to use their mobility device when ambulating, and to use their call bell. An interview with RN #210 indicated that the resident received multiple medications that negatively impacted the resident's gait and that cognitive impairment was a factor in the two previous falls and confirmed that the resident's care plan was not updated to include new strategies and interventions prior to the fall in March 2016. Interview with Kinesiologist confirmed that the resident's falls prevention strategies were not revised after the resident's fall

in February 2016, and that the falls prevention care plan was not effective. An interview with the DOC confirmed that the resident's plan of care as it related to falls prevention was not revised when the care set out in the plan had not been effective. (527)

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

Jan 30, 2017(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall do the following:
1. Ensure all residents are protected from abuse by anyone and are not neglected by the licensee or staff.
2. Ensure the home's policy to promote zero tolerance of abuse and neglect of residents includes all requirements of the LTC Homes Act and regulations, including but not limited to, procedures and interventions to assist and support residents who have been allegedly abused, and that the policy is revised to include procedures and interventions to deal with persons who have allegedly abused residents.
3. Provide education and training of all staff on the above mentioned revised policy to promote zero tolerance of abuse and neglect of residents.
4. Ensure all complaints are inspected as per the LTC Homes Act and regulations, including but not limited to keeping documented records as required.
5. Ensure that evaluations and analysis of every incident of abuse or neglect of a resident are conducted as per the LTC Homes Act and regulations.

Grounds / Motifs :

1. Judgement Matrix
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Isolated
- Compliance History: Despite Ministry of Health (MOH) action, non-compliance (NC) continues with original area of NC.
This finding was previously issued as a Voluntary Plan of Correction (VPC) in 2014 and issued as an Compliance Order (CO) in 2015.

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

Critical incident report submitted by the home on an identified date in March 2016, related to an allegation of abuse by PSW #244 to resident #050 that occurred on an identified date in March 2016, whereby the resident alleged that the staff member physically abused them during care. According to the report submitted by the home, in an interview with staff #205, the resident alleged that staff #244 physically abused them. In an interview, resident #050 declined discussion of the above mentioned incident, stating they could not recall the details, and confirmed that staff #244 no longer provided their care. A review of the resident's written plan of care indicated

that the resident required two PSW staff for the provision of care and that the resident had preferred care givers. A review of the investigation notes revealed a written statement provided by PSW #244, whom resident #050 alleged physically abused them. PSW #244 indicated that they provided care to the resident without the assistance of another staff the night of the incident, as PSW #245 had stepped away to assist with another resident. The staff member stated they proceeded to provide care independently while the resident continued to protest during the care. The staff member did not report the incident to the nurse in charge that shift, but did notify the neighbourhood coordinator, staff #205, by leaving a message on their voicemail at the end of their shift. The home initiated an investigation into the allegation the next day. The investigation notes included the statement of PSW #245 who assisted PSW #244 to care for the resident later that shift, and confirmed that PSW #244 continued to provide care to the resident while the resident actively refused care. Staff #205 as per their statement in the investigation notes, indicated that on assessment of the resident the morning following the incident, they found injuries on the resident but were unable to determine if these injuries were obtained during the provision of care the previous night; however, a nursing assessment of the resident post-incident could not be produced. PSW #244 stated they knew of the instructions in the written plan of care; however, assistance was not available at the time so they continued to provide the care despite the resident's request for them to stop, as they did not want to leave the resident soiled.

Under the Ontario Regulation 79/10 emotional abuse is defined as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident". PSW #244 ignored the resident and continued to provide care despite the resident refusing care by making verbal and physical indications of refusals. The resident was noted to be refusing care and PSW #224 continued to provide care. As per the resident, they felt significantly distraught after the interaction with PSW #244. The licensee did not protect resident #050 from emotional abuse by PSW #244 and #245. (619)

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

Jan 30, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

Issued on this 21 day of November 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SAMANTHA DIPIERO - (A1)

Service Area Office /
Bureau régional de services : Hamilton