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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 24, 2019	2018_575214_0013 (A1)	022826-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

West Park Health Centre
103 Pelham Road St. Catharines ON L2S 1S9

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

Amended by CATHY FEDIASH (214) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Compliance Order Due Date changed from April 29, 2019 to May 28, 2019.

Issued on this 24th day of April, 2019 (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

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

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

Amended by CATHY FEDIASH (214) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 29, 30, 31, September 4, 5, 6, 7, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 2018.

Please note that the following Critical Incident System (CIS) Inspections were conducted concurrently during this Resident Quality Inspection (RQI):

-Log #027899-17- related to Falls Prevention

-Log #008294-17- related to Prevention of Abuse and Neglect

-Log #022562-17- related to Prevention of Abuse and Neglect

-Log #007938-17-related to Falls Prevention

-Log #000582-18-related to Prevention of Abuse and Neglect

-Log #018055-17-related to Prevention of Abuse and Neglect

-Log #010650-18-related to Prevention of Abuse and Neglect

-Log #004766-18-related to Prevention of Abuse and Neglect

-Log #020477-18-related to Falls Prevention

-Log #012072-17-related to Prevention of Abuse and Neglect

-Log #000547-18-related to Prevention of Abuse and Neglect

-Log #004130-18-related to Prevention of Abuse and Neglect

-Log #027732-17-related to Prevention of Abuse and Neglect

-Log #020900-17-related to Prevention of Abuse and Neglect

-Log #006541-18-related to Prevention of Abuse and Neglect

-Log #005822-18-related to Falls Prevention

-Log #016862-17-related to Prevention of Abuse and Neglect

-Log #011616-17-related to Prevention of Abuse and Neglect

-Log #020268-18-related to Prevention of Abuse and Neglect

-Log #020943-18-related to Prevention of Abuse and Neglect

The following Complaint Inspections were conducted concurrently during this RQI:

-Log #011447-17- related to Falls Prevention; Recreational and Social Activities; Training and Orientation

-Log #010173-17- related to Falls Prevention; Recreational and Social Activities

-Log #015273-18- related to Food Quality

-Log #014350-17-related to Continence Care and Bowel Management

-Log #009283-18- related to Food Quality; Prevention of Abuse and Neglect; Reporting and Complaints; Responsive Behaviours; Continence Care and Bowel Management; Nursing and personal support services; Skin and Wound; Safe and secure home; Medication management.

-Log #012903-18- related to Nutrition and Hydration

-Log #022142-17- related to Safe and secure home; Continence care and bowel management

-Log #018743-18- related to Prevention of abuse and neglect; Medication management; Nutrition and Hydration

The following Follow Up (F/U) Inspections was conducted concurrently during this RQI:

-Log #021333-17- related to Responsive Behaviours

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED); Director of Care (DOC); Clinical Nurse Coordinator; Resident Assessment Instrument (RAI) Coordinator; Nursing Clerk; Manager of Food and Environmental Services; Manager of Social Services; Registered Dietitian (RD); Maintenance staff; Physician; Registered Nurses (RNs); Registered Practical Nurses (RPNs); Personal Support Workers (PSWs); Corporate Consultant; residents and family members.

During the course of the inspection, the inspector(s) toured the home; observed staff to resident interactions and the provision of care; observed administration of medications; reviewed resident clinical records; relevant policies and procedures; the home's internal investigative notes; the home's complaint log; Residents' and Family Council meeting minutes; Professional Advisory Committee (PAC) minutes; staff training records and employee files.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **17 WN(s)**
- **5 VPC(s)**
- **2 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
O.Reg 79/10 s. 53. (4)	CO #001	2017_575214_0010	214

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	Légende 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A review of a Medication Incident Report indicated that on an identified date and time, resident #016 had been administered resident #017's prescribed drugs.

An interview with registered staff #230 on an identified date, who was involved in this medication incident, indicated that they had administered resident #017's prescribed drugs to resident #016 on an identified date. The staff member indicated following the administration of the medications, there was another identified medication that was prescribed for resident #017. The staff member indicated this is when they realized they had administered the wrong drugs to resident #016. The staff member indicated they immediately informed the registered nurse on duty who called the physician.

The staff member indicated that they approached resident #016, thinking they were resident #017. The staff member indicated that they then administered resident #017's drugs to resident #016.

An interview with the ED on an identified date, confirmed that drugs had not been administered to resident #016, as prescribed.

B) A review of a Medication Incident Report dated with an identified date, indicated that resident #008 had been administered an extra dose of their identified, prescribed medication. The report indicated that registered staff #141 had been involved.

A review of resident #008's Medication Administration Record, indicated that the resident was prescribed their identified medication to be taken at identified times in the day.

An interview with registered staff #141 indicated that the residents identified drug card was labelled with the days of the week along one side of the card and the times were handwritten across the top of the card. The staff member indicated that when they came on day shift on this date, they noticed that the drug for one of the specific times of administration, was still intact in the drug card. The staff member indicated that they checked the e-MAR and observed that this prescribed dose on this date had been signed for and then checked an identified count record sheet and observed that the identified dose had been signed for this date. The staff member indicated that they thought the identified nurse may have documented the drug as administered but had forgotten to administer as the drug dose was intact. The staff member indicated that the following day, registered staff had conducted a count of the identified drug and noted that the count was inaccurate. They notified registered staff #141, who recognized that the count was not accurate as a result of the extra dose that was administered the day

before. Registered staff #141 indicated that when the identified nurse administered the prescribed, identified drug, they took the drug from the blister labelled for another identified day of the week and not from the blister for the actual day of the week . Registered staff #141 confirmed that during the counting of identified drugs on a specified date, they had counted the drugs with the incoming nurse; however, did not conduct the count with both nurses physically viewing the quantity of drugs in the blister pack. Registered staff #141 confirmed that resident #008 received an extra dose of their identified, prescribed drug.

Registered staff #141 and an interview with the ED, confirmed that drugs had not been administered to resident #008, as prescribed.

PLEASE NOTE: This area of non-compliance was identified during complaint inspection #018743-18, conducted concurrently during the Resident Quality Inspection (RQI).

C) A review of a Medication Incident Report dated with an identified date, indicated that resident #008 had been administered an extra dose of their identified, prescribed medication.

Review of the Medication Incident Report and an interview with registered staff #141 on an identified date and time, indicated that the medication error had been reported to them on this date. The staff member indicated that the residents prescribed drug had been labelled with the days of the week along one side of the card and the times were handwritten across the top of the card. Registered staff #141 indicated that registered staff #145 had administered the resident's prescribed identified drug on a specified date and time; however, had removed the tablet for another identified day of the week and not from the blister for the actual day of the week. The staff member indicated that registered staff #145 and #149 had conducted a count of the identified drugs on this date, at a specified time and registered staff #149 had noticed that the resident's identified drug was still in the blister pack for the identified day of the week and indicated to registered staff #145 that the resident's identified drug had not been administered. Registered staff #141 indicated that registered staff #145 had thought that they did not administer the drug and proceeded to administer the drug to the resident. Registered staff #141 indicated that when the two nurses resumed the narcotic shift count, it was identified that resident #008's identified drug count was inaccurate and that registered staff #145 realized that they had administered the scheduled dose this day and should not have administered the second dose.

A telephone interview with registered staff #145 on an identified date and time, indicated that the information provided by registered staff #141 in relation to this medication incident was accurate. Registered staff #145 indicated that when they seen the identified drug tablet was still intact for a specified dose, they thought they had not administered the medication and proceeded to administer a second dose.

Review of progress notes dated on identified dates and times, indicated that the resident received an extra dose of their prescribed, identified drug.

Registered staff #145 and an interview with the ED on a specified date, confirmed that drugs had not been administered to resident #008, as prescribed.

PLEASE NOTE: This area of non-compliance was identified during complaint inspection #018743-18, conducted concurrently during the Resident Quality Inspection (RQI).

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.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

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

O.Reg. 79/10, s. 2 (1) definition includes sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A) On a specified date, the licensee submitted a CIS report #1500-000002-18, which indicated that the day prior, the home was investigating an allegation of an identified incident towards resident #012. A review of the home's investigative notes and an interview with the Executive Director (ED) on an identified date, indicated that the resident had verbalized an identified action had been taken towards them, resulting in a injury to an identified location of their body by an identified staff member.

During an interview on an identified date, the ED stated that resident #012 and the identified staff member had a specified incident that resulted in the resident sustaining an injury to an identified area of their body. Resident #012 reported the specified incident to an identified source. During an interview on an identified date, resident #012 confirmed the injuries sustained. The ED reported that the identified staffs employment had been terminated with the home as result of the investigation of the incident and that the licensee failed to ensure that resident #012 was protected from identified actions by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #000582-18, conducted concurrently during this RQI.

B) The home submitted a CIS report to the Director on a specified date, of an

identified incident towards resident #014 by resident #013 that had occurred the day prior.

Review of the resident's clinical records and CIS report, indicated that on an identified date, PSW #200 entered resident #013's room and observed resident #013, demonstrating an identified responsive behaviour toward resident #014. The residents were separated and the incident was reported to registered staff #137.

Interview with PSW #200, confirmed the identified incident.

It was confirmed during record reviews and through interviews conducted during this inspection that resident #014 was not protected from identified actions by resident #013..

PLEASE NOTE: This area of non-compliance was identified during a CIS) inspection, log #008294-17, conducted concurrently during this RQI.

C) The home submitted a CIS report to the Director on a specified date, of an identified incident that occurred on the same date.

A review of the CIS indicated that a large group of residents were sitting in an identified location and it was witnessed by staff #111 that resident #019 initiated identified actions towards resident #020.

It was confirmed through review of the clinical records, the CIS report and during an interview with the ED that resident #020 was not protected from identified actions by resident #019.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #011616-17, conducted concurrently during this RQI.

D) The home submitted a CIS report to the Director on a specified date, to report identified action towards resident #015 by resident #013.

A review of the resident's clinical records and the CIS report indicated that on an identified date, staff witnessed resident #013 to approach resident #015 and initiate an identified action. Resident #013 had known, identified responsive behaviours, in response.

At the time of this incident resident #013 had an identified intervention in place due to the responsive behaviours; however, the intervention had just been completed prior to the incident.

It was confirmed through review of the resident's clinical records, the CIS report and during an interview with the ED that resident #015 was not protected from an identified action by resident #013.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log# 020900-17, conducted concurrently during this RQI.

E) The home submitted a CI report to the Director on a specified date, to report an identified incident towards resident #023 by resident #013.

A review of the resident's clinical records and a CIS report indicated that on a specified date , resident #013 was witnessed by a staff member to demonstrate an identified, responsive behaviour to resident #023.

Resident #013 had known responsive behaviours of a similar nature.

It was confirmed through review of the resident's clinical records, the CIS report and during interview with the ED that resident #023 was not protected from an identified action by resident #013.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #012072-17, conducted concurrently during this RQI.

F) The home submitted a CIS report to the Director on a specified date, of an identified incident to resident #028 by resident #013 that occurred on this date.

Resident #013 had an identified diagnosis and known responsive behaviours of a similar nature.

Review of the resident's clinical records and CIS report, indicated that on this date, it was witnessed by a PSW that resident #013 initiated an identified action towards resident #028. This was reported to registered staff #139 who had documented the incident in the resident's clinical record.

During an interview with staff #139, the staff confirmed that resident #013 had a history of identified, similar responsive behaviours.

It was confirmed during record reviews and through interview with staff #139 that resident #028 was not protected from an identified action by resident #013.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #004766-18, conducted concurrently during this RQI.

G) The home submitted a CIS report to the Director on a specified date, of an identified incident.

A review of the CIS and the resident's clinical records indicated that it was witnessed by registered staff #153 that resident #019 initiated an identified action towards resident #015.

It was confirmed through review of the clinical records, the CIS report and during an interview with the ED that resident #015 was not protected from an identified incident, by resident #019.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #016862-17, conducted concurrently during this RQI.

H) A review of CIS #1500-000027-18, indicated that on an identified date and time, resident #034 was observed by staff to have demonstrated an identified responsive behaviour towards resident #020.

Review of an identified assessment for resident #034 indicated that they demonstrated the identified responsive behaviour towards resident #020 and that this was witnessed by staff.

During an interview with the DOC on an identified date, it was indicated that resident #020 had not sustained any harm or ill effects as a result of this incident. The DOC indicated that both residents were immediately separated and an identified intervention was put into place for resident #034.

During an interview with the DOC they confirmed that resident #020 had not been protected from an identified incident by resident #034.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #020268-18, conducted concurrently during this RQI.

I) A review of a CIS #1500-000028-18, indicated that on a specified date, resident #034 was observed by staff to have initiated a responsive behaviour toward resident #020.

Review of an identified assessment for resident #034 for this identified incident, indicated that resident #034 was witnessed by staff to have demonstrated the responsive behaviour while at an identified location.

Review of a progress note for resident #020, dated the same date as the CIS, indicated that resident #020 was involved in an identified incident that had been initiated by resident #034.

During an interview with the DOC on an identified date, it was indicated that staff took immediate action and resident #020 had not sustained any harm or ill effects as a result of this incident.

During an interview with the DOC on an identified date, they confirmed that resident #020 had not been protected from an identified incident, by resident #034..

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #020943-18, conducted concurrently during the RQI.

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 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) According to the clinical health record for resident #007, they were identified with a risk for falls. The plan of care dated on an identified date, for this resident outlined interventions, which included the use of a specified fall intervention.

Resident #007 was observed in a specified location on an identified date, and did not have the identified fall intervention in place. Interviews took place on an identified date, with staff #162, #178, #190, and #194. All four identified staff confirmed that resident #007 should have had the fall intervention in place. A subsequent interview with the DOC further confirmed that resident #007 did not have the identified fall intervention in place on an identified date and the care set out in the plan of care pertaining to the fall intervention was not provided to resident #007.

B) A review of the clinical health records for resident #009 indicated on a specified date that resident #009 had an order from the physician directing staff to perform an identified treatment on a specified date. A subsequent physician's order dated on another identified date, directed staff to perform the identified treatment on a different specified date.

According to the plan of care for resident #009, they were to have the identified

treatment completed on a specified date for three identified months in an identified year and they were to have the identified treatment performed on another identified day for four other identified months. Resident #009 did not have their identified treatment performed on the identified days for four identified months.

In an interview conducted with the DOC on an identified date, after review of the clinical health record for resident #009, confirmed that the care set out in the plan of care for this resident was not provided as specified in the plan.

PLEASE NOTE: This area of non compliance was identified during complaint inspection Log #022142-17, conducted concurrently during this RQI.

C) During an interview with staff #214, during stage one of the RQI, it was identified that resident #002 had a specified alteration to their skin to an identified area.

A review of a current, identified assessment, dated with an identified date, indicated that the resident had a specified degree of alteration to their skin.

A review of the e-TAR for an identified month and year, indicated that staff were to provide a specified treatment to the altered skin and to check the dressing and change as identified.

A review of the e-TAR for the identified month and year, indicated that no documentation was recorded for this treatment.

An interview with registered staff #140 on an identified date, who was responsible for the resident's treatment, indicated that they had been unable to complete the check or treatment to the resident's identified area of skin alteration, as they were unable to get to the treatment due to other issues going on in the home.

Registered staff #140 confirmed that treatment was not provided to resident #002 as specified in their plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and it was complied with.

A review of the home's policy titled, Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01 last updated on an identified date and year, indicated the following:

i) Under "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting": Any form of abuse of neglect by any person interacting with residents, whether through deliberate acts or negligence will not be tolerated.

ii) All staff immediately respond to any form of alleged, potential, suspected or witnessed abuse (physical, verbal, emotional, sexual, financial and neglect).

iii) Ensure the safety of, and provide support to the abuse victim(s), through completion of full assessments, a determination of resident's needs and a documented plan to meet those needs.

iv) Anyone who witnesses or suspects abuse or neglect of a resident by another

resident, staff or other person must report the incident. The report may be made by the home and/or external authorities. At minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately.

A) A review of a Critical Incident System that was submitted by the home on a specified date, indicated the home was investigating an allegation of an identified nature involving an identified staff towards resident #012. A review of the home's investigative notes and an interview with the ED on a specified date, indicated that the resident had verbalized an identified action had been taken towards them, resulting in a injury by an identified staff member, on a specified date and time of day.

During an interview on an identified date, the ED stated that resident #012 had reported the alleged, identified action, to an identified source. Investigative notes indicated that staff #227 informed registered staff #228 of the alleged incident and that resident #012 had notified an identified source. Staff #227 also indicated that the identified source arrived to the home on the same date. During an interview on an identified date, the ED stated that registered staff #228 did not respond immediately to the alleged incident or determine resident's #012 needs through completion of a full assessment. A review of staff #227's weekly time sheets confirmed that the suspected staff member continued to provide care until their shift ended. A review of resident #012's clinical record indicated that no documentation containing a detailed description of the alleged incident or assessment, had been recorded in the resident's record at the time of the incident. The ED confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents had not been complied with.

PLEASE NOTE: This area of non-compliance was identified during a CIS Inspection, log #000582-18, conducted concurrently during this RQI.

B) A review of a CIS that was submitted by the home on a specified date, indicated the home was investigating an allegation of an identified nature involving an identified staff towards resident #018. A review of the home's investigative notes and an interview with the ED on an identified date indicated that registered staff #228 was aware that staff #169 allegedly provided care to resident #018 in an identified manner, on the identified date.

During an interview on an identified date, the ED stated that registered staff #228 did not respond immediately to the alleged, identified incident or determined resident #018's needs through completion of a full assessment. During an interview on an identified date, registered staff #139 indicated that when an alleged incident of this identified nature is reported to registered staff, a risk management form is completed and assessment of the resident is documented. A review of resident #018's clinical record indicated that no documentation containing a detailed description of the alleged incident or assessment had been recorded in the resident's record at the time of the alleged incident. The ED and registered staff #139 confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents had not been complied with.

PLEASE NOTE: This area of non-compliance was identified during a CIS Inspection, log #018055-17, conducted concurrently during this RQI.

C) A review of the clinical records revealed that on a specified date, resident #013 was observed by a PSW, to demonstrate an identified respnsive behaviour to resident #014.

The residents were then separated by staff and the incident was reported by the PSW to RPN #161.

During an interview with the ED on an identified date, the ED reviewed this incident which had been documented in the resident's clinical record and confirmed that this incident should have been reported to the management and to the Director as directed in their policy.

D) A review of a CIS report submitted to the Director on a specified date, and review of resident #019's clinical records indicated that four days prior at an identified time, it was witnessed by registered staff #153 that resident #019 demonstrated an identified responsive behaviour toward resident #015. Staff intervened and separated the residents.

During an interview with the DOC on an identified date, it was confirmed that the Director had not been informed of the incident, until four days later.

PLEASE NOTE: This area of non-compliance was identified during a CIS

inspection, log #016862-17, conducted concurrently during this RQI. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) During an interview with the ED on an identified date and time, it was confirmed that an annual program evaluation for the homes skin and wound

program had not been conducted. The ED indicated that home met approximately four times throughout an identified year and discussed individual resident skin and wound needs as well as skin and wound statistics, however, had not formally evaluated the program.

B) On an identified date, a review of the homes Falls Prevention and Management Program (RC-15-01-01) took place.

During an interview with the Long Term Care Homes (LTCH) Inspector on a specified date, the ED confirmed that the home had not completed the annual program evaluation for falls prevention.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #027899-17, conducted concurrently during this RQI.

C) On two identified dates, a review of the homes Continence Care and Bowel Management Program took place.

During an interview with the LTCH Inspector on a specified date, the ED confirmed that the home had not completed the annual evaluation for continence care and bowel management.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #022142-17, conducted concurrently during this RQI. [s. 30. (1) 3.]

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

A) A CIS report was submitted to the Director on a specified date, regarding an incident that occurred between two residents the day prior.

According to the CIS, resident #013 had demonstrated an identified responsive behaviour toward resident #014. Staff immediately separated the residents.

A review of the clinical record for resident #014 indicated that when the incident was discovered it was reported to registered staff #137. Registered staff #137 reported the incident to the DOC, the ED and the Physician. They also contacted other identified individuals.

The physician assessed resident #014. Staff #137 was present with the physician during this assessment. During an interview with staff #137, the staff confirmed that the assessment had been done; however, this assessment had not been documented.

The ED also confirmed after review of the resident's clinical record, including the electronic record and paper documentation that this assessment had not been documented.

It was confirmed through documentation review and during interviews with the ED and registered staff #137, that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions had not been documented.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #008294-17, conducted concurrently during this RQI.

B) During an interview with staff #214, during stage one of the RQI, it was identified that resident #002 had an identified area of altered skin integrity.

A review of a current, identified assessment in PCC, dated with an identified date, indicated that the resident had an identified area of skin alteration.

A review of the e-TAR for a specified month and year, indicated that staff were to perform and identified treatment and check the dressing as identified.

A review of the e-TAR for a specified month, indicated that no documentation was recorded for this treatment on two identified dates. An interview with registered staff #143, who was responsible for the resident's treatment on the identified dates, indicated that they had completed the treatment; however, had not documented in the e-TAR for both of the dates identified.

Registered staff #143 confirmed that treatments were to be documented in the e-TAR upon their completion and had not been for the dates identified.

C) A review of resident #003's clinical records during stage one of the RQI, indicated that on a specified date, the resident had an identified alteration to their skin.

A review of a current, identified assessment, dated with an identified date, indicated that the resident had a specified degree of alteration to their skin.

An interview with the resident's physician on an identified date, indicated that the resident's alteration to their skin was declining.

A review of the e-TAR for two identified months during an identified year, indicated that staff were to perform a specified treatment and check the dressing as identified.

A review of the e-TAR for two identified months during an identified year, indicated that no documentation had been recorded for this treatment on five identified dates. An interview with registered staff #146, who was responsible for the resident's treatment on two of the identified dates, indicated that they had completed the treatment on these dates; however, had not documented in the e-TAR for both of the dates identified.

An interview with registered staff #143, who was responsible for the resident's treatment on three identified dates, indicated that they had completed the treatment on these dates; however, had not documented in the e-TAR for the dates identified.

During the interviews with registered staff #143 and #146, they indicated that they did not have tablets on their treatment carts to sign the e-TAR following administration of the treatment and due to identified reasons would forget to go to the tablets or computer and document the completion of their treatments.

D) A review of resident #011's clinical record indicated that an identified assessment, dated with a specified date, indicated that the resident had been referred for an identified alteration to their skin.

Review of an identified assessment and dated with a specified date, indicated that the resident was assessed to have an identified area of altered skin integrity.

Review of progress notes indicated that the resident had been transferred to hospital on an identified date and returned back to the long term care home, an identified time period later. A progress note dated with an identified date and time, indicated that a referral was made to the wound care champion following the

residents return from hospital for their area of altered skin integrity. A progress note dated with an identified date and time, indicated that a change in treatment was implemented. A corresponding, identified assessment, dated with an identified date, indicated that the resident's altered skin integrity had been assessed for a specified degree of alteration.

A review of the e-TAR for an identified month and year, indicated that staff were to perform an identified treatment and check the dressing as identified.

A review of the e-TAR indicated that that no documentation was recorded for this treatment on a specified date and year.

An interview with registered staff #137 on an identified date and time, indicated that they had completed the treatment on this date; however, had forgotten to document in the e-TAR that the treatment had been administered.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all foods and fluids were prepared, stored, and served using methods which prevented adulteration, contamination and food borne-illness.

A review of complaint log #009283-18 identified specified concerns. On an identified date, a bin of small plastic bowls were observed in the main kitchen. Many of the bowls were identified to have small food particles on them that could be seen and or felt. The following day, the dishes in the serveries on identified floors were observed. The remaining dishes in the servery after a specified meal were observed by the LTCH Inspector and dietary staff #109 and #120 acknowledged they were where the clean dishes were stored. Upon observation, it was identified that the remaining dishes, bowls, plates and cutlery were identified to have small food particles on them. The small plastic bowls observed to be unclean in the main kitchen on an identified date, were again observed and dietary staff #103 acknowledged that they were dirty.

The dishes in one of the identified serveries were again observed prior to a specified meal service on the clean dishes cart and the LTCH Inspector identified a lip plate and a two-handled cup with food particles on them. The inspector returned to the main kitchen and identified that the small plastic bowls that were unclean remained in the bin with the clean dishes. The identified dishes were removed for review by the Manager of Food and Environmental Services.

In an interview with the Manager of Food and Environmental Services on an identified date, they acknowledged that the lip plate, two-handled cup and the four plastic dessert bowls brought into their office by the LTCH Inspector were not clean and were not appropriate to be used to serve food to residents.

The home did not ensure that all foods were served using methods which prevented adulteration, contamination and food borne-illness when dishes were used that had food debris on them. [s. 72. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all foods and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness, to be implemented voluntarily.

WN #7: 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 :

1. The licensee failed to ensure that a documented record was kept in the home that included: (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.

A) A review of complaint log #014350-17, submitted to the Director on an identified date, identified specified concerns related to resident #005. In the complaint intake, it was identified that the complainant expressed their concerns

to staff #226, who was identified to be in charge of the nursing department at the time, and staff #226 requested that the complainant give them an identified time frame to investigate.

In an interview with the ED on an identified date, they acknowledged that at the time of this inspection, they were unable to locate records related to complaints from the identified year.

The home did not ensure that the documented record was kept related to complaints from the identified year.

PLEASE NOTE: This area of non compliance was identified during complaint inspection, log #014350-17, conducted concurrently during this RQI.

B) A review of complaint log #011447-17 and complaint log #010173-17 submitted on identified dates, was conducted. These complaints identified specified concerns related to resident #006. In an interview with the complainant on an identified date, it was identified that the complainant expressed their concerns to staff #226, who was identified to be in charge of the nursing department at the time.

In an interview with the ED on a specified date, it was acknowledged that at the time of this inspection, the home did not complete a documented record of an identified complaint log.

PLEASE NOTE: This area of non compliance was identified during two complaint inspections, log #011447-17 and log #010173-17, conducted concurrently during this RQI. [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 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 is 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 is 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 #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 11.iv.: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date, the initial tour of the home was completed as part of the RQI. Part of this tour included the review of the posting of information. In a binder labelled "Mandatory Postings," in the front lobby of the home, the licensee copy identified inspection reports were posted instead of the public copies of these reports. Both inspection reports contained personal health information of residents, which resulted in the home not protecting the resident right to have their personal health information kept confidential.

In an interview with the ED on an identified date, they confirmed that the licensee copies of the identified reports were inadvertently posted in the home. [s. 3. (1) 11. iv.]

WN #9: 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 :

1. The licensee failed to ensure that where the Act or the Regulation required that

licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 68, the licensee was required to ensure that the nutrition care program included a weight monitoring system to measure and record the weight of each resident at admission and monthly thereafter.

Specifically, staff did not comply with the licensee's policy regarding Height and Weight Monitoring, RC-18-01-06, last updated on a specified date, which is part of the licensee's nutrition care and dietary service program. The policy identified that any weight with a 2.5 kilogram (kg) difference from the previous month required a re-weigh to ensure accuracy. The identified policy also indicated that staff were to ensure the current, accurate weight of individual residents, including re-weigh if applicable, was recorded by the identified day of each month either on paper or electronically and entered in the resident's health care record.

A review of complaint log #018743-18 identified specified concerns for resident #008. A review of the electronic record for resident #008 on a specified date, identified that the resident's last documented weight for a specific month and year. The month prior, the resident's weight was documented with an identified amount. This represented an identified weight change in an identified month.

In an interview with the RD on an identified date, they reviewed the resident's weight and identified that the resident required a re-weigh, as per the home's policy, which was supposed to be done by a specified day of the month. They confirmed that they had not received any referrals for the resident's identified weight change. They identified that they would request a re-weigh and would complete a nutritional assessment if there was still a significant weight change.

A review of the electronic record on a specified date, identified that a re-weigh for the resident was done on an identified date, and a referral to the RD was made.

In an interview with the ED, they acknowledged that the home did not comply with their Height and Weight Monitoring policy when resident #008 was not re-weighed before the specified day of the month after a significant weight change was identified.

PLEASE NOTE: This area of non compliance was identified during complaint inspection, log #018743-18, conducted concurrently during this RQI. [s. 8. (1)

(a),s. 8. (1) (b)]

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of complaint logs #011447-17 and Log #010173-17 took place on two identified dates. On an identified date, the inspector spoke with the complainant regarding the above noted intakes associated with the care being provided to resident #006. The complainant acknowledged that on more than one occasion, a specified action had occurred to an identified item belonging to resident #006. The complainant identified that staff #179 may have knowledge of the specified action.

An interview was conducted with staff #179 on an identified date and the staff member was not able to recall the specified action or outcome.

An interview was conducted with registered staff #139 on an identified date and this staff member was able to confirm that a specified action had occurred to an identified item belonging to resident #006. Registered staff #139 was not able to recall a date, or specific staff members involved. An interview was conducted on an identified date with staff #226, who was identified to be in charge of the nursing department at the time of the incident. Staff #226 confirmed that the identified action had occurred.

PLEASE NOTE: This area of non compliance was identified during two complaint inspections, log #011447-17 and log #010173-17, conducted concurrently during this RQI. [s. 36.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

A) A review of complaint log #018743-18 identified specified concerns between resident #019 and resident #008 and identified that an identified intervention for resident #008's was not in place. A review of the written plan of care for resident #008 identified that the resident demonstrated identified, responsive behaviours and staff were to implement an identified intervention.

A review of resident #019's written plan of care identified that they demonstrated identified responsive behaviours. Specific interventions to be in place, were identified.

A review of resident #008's written plan of care identified occasions during a specified period of five months, during a specified year, where resident #019 was found to have demonstrated the identified responsive behaviours.

An identified area was observed on identified times during an identified date and the specified intervention was not observed to be in place.

In interviews with PSW #197 and RPN #162 on a specified date, they identified that resident #008 demonstrated specified responsive behaviours. On an identified date, RPN #166 was interviewed with resident #008 present as they

were demonstrating responsive behaviours at the time and RPN #166 wanted to monitor them. During the interview, resident #008 was demonstrating an identified responsive behaviour.

At a specified time on an identified date, resident #008 was observed to be in an identified location and the specified intervention was not observed to be in place. RPN #149 was interviewed at the time and they acknowledged that the identified intervention should have been in place.

In an interview with registered staff #139 on an identified date, they acknowledged that resident #008's specified intervention should be in place.

The home did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #019 and #008, including implementing the identified intervention on identified dates.

PLEASE NOTE: This area of non compliance was identified during complaint inspection, log #018743-18, conducted concurrently during this RQI.

B) A review of CIS #1500-000027-18, indicated that on an identified date and time, resident #034 was observed by staff to have demonstrated an identified responsive behaviour to resident #020.

A review of a CIS #1500-000028-18, indicated that on an identified date and time, resident #034 was observed by staff to have demonstrated an identified responsive behaviour to resident #020.

An interview with the DOC on an identified date, indicated that following the incident on a specified date, a specified intervention was put into place for resident #034. A review of resident #034's progress notes, dated on an identified date and time, indicated that the specified intervention had been put into place.

A review of resident #034's progress notes dated for an identified date and specified time, indicated that the home was short staffed and the specified intervention was not provided on the identified date.

An interview with staff #223 on an identified date and specified time, confirmed that no staff were in place to provide a specified intervention on an identified date.

During an interview with the DOC on an identified date, it was confirmed that due to a staff shortage, the intervention had not been implemented at the time of the incident on a specified date.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #020943-18, conducted concurrently during this RQI. [s. 54. (b)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that if the Resident's Council advised them of concerns or recommendations under either paragraph 6 or 8 of subsection (1), that they responded to the Resident's Council in writing within 10 days of receiving the advice.

A review of the Resident's Council meeting minutes identified a "Resident/Family Council Meeting Minutes Concerns/Suggestions" form with an identified date. The form identified a specified concern. The form identified that it was to go to the nursing department but did not identify a response to the concern, did not have a comment from the ED and was not signed.

In an interview with the ED on an identified date, they acknowledged that the concern was not forwarded to the DOC and confirmed that the home did not respond to the identified Residents' Council concern in writing within 10 days of receiving the concern. [s. 57. (2)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact

information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

On an identified date, the initial tour of the home was completed as part of the RQI. Part of this tour included the review of the posting of information. In a binder labelled "Mandatory Postings," in the front lobby of the home, two specified inspections, with an identified date, were posted and no other inspection reports were identified in the binder.

In an interview with the ED on a specified date, they identified that the "Mandatory Postings" binder was the only location where inspection reports were posted and they acknowledged that there were other reports prior, that should have been posted.

The home did not ensure that copies of the inspection reports from the past two years for the long-term care home were posted. [s. 79. (3) (k)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

The ED was unable to provide documentation that an evaluation had been completed and confirmed in an interview on an identified date, that the annual evaluation to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents was not completed for a specified year. [s. 99. (b)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every licensee that the licensee shall comply with every order made under this Act.

On an identified date, the following compliance order (CO #001) from inspection #2017_575214_0010 was made under O. Reg. 79/10, s. 53(4)(c):

1. The licensee shall ensure that for each resident demonstrating responsive behaviours, including resident #100, that 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.

2. The licensee shall provide education on documentation requirements for each resident demonstrating responsive behaviours and the requirement to ensure that the resident's responses to interventions are documented. This education shall be provided to all staff who are responsible for documenting resident's behaviours.

3. The licensee shall conduct auditing activities of resident's clinical records at a frequency and schedule as they determine to ensure that actions are taken to respond to the needs of resident's and that the resident's responses to interventions are documented for each resident demonstrating responsive behaviours.

Resident #100 was not in the home at the time of this follow-up inspection. Incidents of responsive behaviours were reviewed involving residents #013, #019

and #028 and the records reviewed met the requirement under section #1 of this order.

On an identified date, the ED provided the education that was provided to staff by a specified date, which met the requirement under section #2 of this order.

On an identified date, when asked for the audits conducted of resident's clinical records, the ED confirmed that section #3 of this order had not been met.

The licensee failed to complete section #3 of CO #001 to conduct auditing activities of resident's clinical records at a frequency and schedule as they determined to ensure that actions were taken to respond to the needs of resident's and that the resident's responses to interventions were documented for each resident demonstrating responsive behaviours.

PLEASE NOTE: This area of non-compliance was identified during a Follow Up inspection #021333-17, conducted concurrently during this RQI. [s. 101. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system.

An interview with the ED, confirmed that the home had not met annually to evaluate the effectiveness of the medication management system in the home. [s. 116. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview with the DOC on an identified date, it was indicated that the home reviewed quarterly medication incidents and adverse drug reactions at the Professional Advisory Committee Meetings (PAC). The DOC indicated that the home last reviewed medication incidents and adverse drug reactions for an identified three month period and year.

The ED provided a copy of the PAC meeting minutes for the quarterly review of the above time period. A review of the meeting minutes, dated for an identified date, indicated under item number two, that the pharmacy provided a report in relation to the medication incidents that occurred in the home for the identified quarterly period. The report indicated that there had been an identified total of medication errors for the three month period of time reviewed. The report indicated identified reasons for the errors; however, no further information was recorded in the quarterly review in relation to the type of errors that occurred; when the errors occurred and whether the errors were nursing or pharmacy related.

An interview with the DOC and Clinical Nurse Coordinator was held on an identified date. The PAC meeting minutes were reviewed and the DOC confirmed that the minutes had contained statistics in relation to the medication incidents and that the quarterly review had not contained a review that included the type of medication incidents; time of incidents; nature of incidents; interventions put into place at the time of the incidents and whether or not the interventions had been effective in reducing and preventing the medication incidents.

An interview with the DOC confirmed that the home had met to conduct a quarterly review of all medication incidents in the home for an identified period of time; however, the review had not contained information specific to reducing and preventing the medication incidents and any adverse reactions. [s. 135. (3)]

Issued on this 24th day of April, 2019 (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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by CATHY FEDIASH (214) - (A1)
Inspection No. / No de l'inspection :	2018_575214_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022826-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 24, 2019(A1)
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	West Park Health Centre 103 Pelham Road, St. Catharines, ON, L2S-1S9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sharon Darby

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 CVH (No. 1) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, s. 131(2).

Specifically, the licensee must:

a) Ensure that resident #016 and all other residents prescribed to receive routine drugs, are administered the routine drugs in accordance with the directions for use specified by the prescriber.
b) Ensure that resident #008 and all other residents prescribed to receive narcotic drugs are administered the narcotic drugs in accordance with the directions for use specified by the prescriber.

The licensee shall liaise with the pharmacy provider to develop and implement an educational in-service specific to ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber. The educational in-service shall include, but not limited to the following:

1) Review of the College of Nurses (CNO) Medication Practice Standard, revised 2017.
2) Review of the licensee's expectations of counting and documenting narcotics at shift change.

These educational in-services shall be provided to all registered staff and contract registered staff at the home, who are responsible for the administration of drugs. This educational in-service shall be documented and include the names and designation of all staff in attendance.

Grounds / Motifs :

1. 1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A review of a Medication Incident Report indicated that on an identified date and time, resident #016 had been administered resident #017's prescribed drugs.

An interview with registered staff #230 on an identified date, who was involved in this medication incident, indicated that they had administered resident #017's prescribed drugs to resident #016 on an identified date. The staff member indicated following

the administration of the medications, there was another identified medication that was prescribed for resident #017. The staff member indicated this is when they realized they had administered the wrong drugs to resident #016. The staff member indicated they immediately informed the registered nurse on duty who called the physician.

The staff member indicated that they approached resident #016, thinking they were resident #017. The staff member indicated that they then administered resident #017's drugs to resident #016.

An interview with the ED on an identified date, confirmed that drugs had not been administered to resident #016, as prescribed.

B) A review of a Medication Incident Report dated with an identified date, indicated that resident #008 had been administered an extra dose of their identified, prescribed medication. The report indicated that registered staff #141 had been involved.

A review of resident #008's Medication Administration Record, indicated that the resident was prescribed their identified medication to be taken at identified times in the day.

An interview with registered staff #141 indicated that the residents identified drug card was labelled with the days of the week along one side of the card and the times were handwritten across the top of the card. The staff member indicated that when they came on day shift on this date, they noticed that the drug for one of the specific times of administration, was still intact in the drug card. The staff member indicated that they checked the e-MAR and observed that this prescribed dose on this date had been signed for and then checked an identified count record sheet and observed that the identified dose had been signed for this date. The staff member indicated that they thought the identified nurse may have documented the drug as administered but had forgotten to administer as the drug dose was intact. The staff member indicated that the following day, registered staff had conducted a count of the identified drug and noted that the count was inaccurate. They notified registered staff #141, who recognized that the count was not accurate as a result of the extra dose that was administered the day before. Registered staff #141 indicated that when the identified nurse administered the prescribed, identified drug, they took the drug from the blister labelled for another identified day of the week and not from the

blister for the actual day of the week . Registered staff #141 confirmed that during the counting of identified drugs on a specified date, they had counted the drugs with the incoming nurse; however, did not conduct the count with both nurses physically viewing the quantity of drugs in the blister pack. Registered staff #141 confirmed that resident #008 received an extra dose of their identified, prescribed drug.

Registered staff #141 and an interview with the ED, confirmed that drugs had not been administered to resident #008, as prescribed.

PLEASE NOTE: This area of non-compliance was identified during complaint inspection #018743-18, conducted concurrently during the Resident Quality Inspection (RQI).

C) A review of a Medication Incident Report dated with an identified date, indicated that resident #008 had been administered an extra dose of their identified, prescribed medication.

Review of the Medication Incident Report and an interview with registered staff #141 on an identified date and time, indicated that the medication error had been reported to them on this date. The staff member indicated that the residents prescribed drug had been labelled with the days of the week along one side of the card and the times were handwritten across the top of the card. Registered staff #141 indicated that registered staff #145 had administered the resident's prescribed identified drug on a specified date and time; however, had removed the tablet for another identified day of the week and not from the blister for the actual day of the week. The staff member indicated that registered staff #145 and #149 had conducted a count of the identified drugs on this date, at a specified time and registered staff #149 had noticed that the resident's identified drug was still in the blister pack for the identified day of the week and indicated to registered staff #145 that the resident's identified drug had not been administered. Registered staff #141 indicated that registered staff #145 had thought that they did not administer the drug and proceeded to administer the drug to the resident. Registered staff #141 indicated that when the two nurses resumed the narcotic shift count, it was identified that resident #008's identified drug count was inaccurate and that registered staff #145 realized that they had administered the scheduled dose this day and should not have administered the second dose.

A telephone interview with registered staff #145 on an identified date and time,

indicated that the information provided by registered staff #141 in relation to this medication incident was accurate. Registered staff #145 indicated that when they seen the identified drug tablet was still intact for a specified dose, they thought they had not administered the medication and proceeded to administer a second dose.

Review of progress notes dated on identified dates and times, indicated that the resident received an extra dose of their prescribed, identified drug.

Registered staff #145 and an interview with the ED on a specified date, confirmed that drugs had not been administered to resident #008, as prescribed.

PLEASE NOTE: This area of non-compliance was identified during complaint inspection #018743-18, conducted concurrently during the Resident Quality Inspection (RQI).

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 3 history of on-going non-compliance with this section of the O.Reg 79/10 that included:

• Voluntary Plan of Correction (VPC) issued July 11, 2016, (2016_250511_0006/008291-16).

(214)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 28, 2019(A1)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 must be compliant with s. 19 (1) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee shall ensure that:

1. Residents #012, #020, #023 and all other residents are protected from abuse by anyone.

2. The plans of care for residents #019 and #034, shall be reviewed within one week (7 days) of receiving this report, to ensure that interventions related to responsive behaviours continue to be effective in minimizing the risks of altercations and potentially harmful interactions between and amongst residents.

3. Provide mandatory re-education of the licensee's policy for Prevention of Abuse and Neglect to all staff who provide direct care, including definitions of sexual abuse; non-consensual touching and reporting requirements. This education is to be completed by a method of the home's discretion.

4. Provide mandatory re-education of the licensee's policy for the Management of Responsive Behaviours, to all staff who provide direct care.

5. Initiate quality monitoring activities and analysis to ensure ongoing compliance with the home's Prevention of Abuse and Responsive Behaviour policies.

Grounds / Motifs :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

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

O.Reg. 79/10, s. 2 (1) definition includes sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A) On a specified date, the licensee submitted a CIS report #1500-000002-18, which indicated that the day prior, the home was investigating an allegation of an identified incident towards resident #012. A review of the home's investigative notes and an interview with the Executive Director (ED) on an identified date, indicated that the resident had verbalized an identified action had been taken towards them, resulting in a injury to an identified location of their body by an identified staff member.

During an interview on an identified date, the ED stated that resident #012 and the identified staff member had a specified incident that resulted in the resident sustaining an injury to an identified area of their body. Resident #012 reported the specified incident to an identified source. During an interview on an identified date, resident #012 confirmed the injuries sustained. The ED reported that the identified staffs employment had been terminated with the home as result of the investigation of the incident and that the licensee failed to ensure that resident #012 was protected from identified actions by anyone.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection, log #000582-18, conducted concurrently during this RQI.

B) The home submitted a CIS report to the Director on a specified date, of an identified incident towards resident #014 by resident #013 that had occurred the day prior.

Review of the resident's clinical records and CIS report, indicated that on an identified date, PSW #200 entered resident #013's room and observed resident #013, demonstrating an identified responsive behaviour toward resident #014. The

residents were separated and the incident was reported to registered staff #137.

Interview with PSW #200, confirmed the identified incident.

It was confirmed during record reviews and through interviews conducted during this inspection that resident #014 was not protected from identified actions by resident #013..

PLEASE NOTE: This area of non-compliance was identified during a CIS) inspection, log #008294-17, conducted concurrently during this RQI.

C) The home submitted a CIS report to the Director on a specified date, of an identified incident that occurred on the same date.

A review of the CIS indicated that a large group of residents were sitting in an identified location and it was witnessed by staff #111 that resident #019 initiated identified actions towards resident #020.

It was confirmed through review of the clinical records, the CIS report and during an interview with the ED that resident #020 was not protected from identified actions by resident #019.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #011616-17, conducted concurrently during this RQI.

D) The home submitted a CIS report to the Director on a specified date, to report identified action towards resident #015 by resident #013.

A review of the resident's clinical records and the CIS report indicated that on an identified date, staff witnessed resident #013 to approach resident #015 and initiate an identified action. Resident #013 had known, identified responsive behaviours, in response.

At the time of this incident resident #013 had an identified intervention in place due to the responsive behaviours; however, the intervention had just been completed prior to the incident.

It was confirmed through review of the resident's clinical records, the CIS report and during an interview with the ED that resident #015 was not protected from an identified action by resident #013.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log# 020900-17, conducted concurrently during this RQI.

E) The home submitted a CI report to the Director on a specified date, to report an identified incident towards resident #023 by resident #013.

A review of the resident's clinical records and a CIS report indicated that on a specified date , resident #013 was witnessed by a staff member to demonstrate an identified, responsive behaviour to resident #023.

Resident #013 had known responsive behaviours of a similar nature.

It was confirmed through review of the resident's clinical records, the CIS report and during interview with the ED that resident #023 was not protected from an identified action by resident #013.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #012072-17, conducted concurrently during this RQI.

F) The home submitted a CIS report to the Director on a specified date, of an identified incident to resident #028 by resident #013 that occurred on this date.

Resident #013 had an identified diagnosis and known responsive behaviours of a similar nature.

Review of the resident's clinical records and CIS report, indicated that on this date, it was witnessed by a PSW that resident #013 initiated an identified action towards resident #028. This was reported to registered staff #139 who had documented the incident in the resident's clinical record.

During an interview with staff #139, the staff confirmed that resident #013 had a history of identified, similar responsive behaviours.

It was confirmed during record reviews and through interview with staff #139 that resident #028 was not protected from an identified action by resident #013.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #004766-18, conducted concurrently during this RQI.

G) The home submitted a CIS report to the Director on a specified date, of an identified incident.

A review of the CIS and the resident's clinical records indicated that it was witnessed by registered staff #153 that resident #019 initiated an identified action towards resident #015.

It was confirmed through review of the clinical records, the CIS report and during an interview with the ED that resident #015 was not protected from an identified incident, by resident #019.

PLEASE NOTE: This area of non-compliance was identified during a CI inspection, log #016862-17, conducted concurrently during this RQI.

H) A review of CIS #1500-000027-18, indicated that on an identified date and time, resident #034 was observed by staff to have demonstrated an identified responsive behaviour towards resident #020.

Review of an identified assessment for resident #034 indicated that they demonstrated the identified responsive behaviour towards resident #020 and that this was witnessed by staff.

During an interview with the DOC on an identified date, it was indicated that resident #020 had not sustained any harm or ill effects as a result of this incident. The DOC indicated that both residents were immediately separated and an identified intervention was put into place for resident #034.

During an interview with the DOC they confirmed that resident #020 had not been protected from an identified incident by resident #034.

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection

#020268-18, conducted concurrently during this RQI.

I) A review of a CIS #1500-000028-18, indicated that on a specified date, resident #034 was observed by staff to have initiated a responsive behaviour toward resident #020.

Review of an identified assessment for resident #034 for this identified incident, indicated that resident #034 was witnessed by staff to have demonstrated the responsive behaviour while at an identified location.

Review of a progress note for resident #020, dated the same date as the CIS, indicated that resident #020 was involved in an identified incident that had been initiated by resident #034.

During an interview with the DOC on an identified date, it was indicated that staff took immediate action and resident #020 had not sustained any harm or ill effects as a result of this incident.

During an interview with the DOC on an identified date, they confirmed that resident #020 had not been protected from an identified incident, by resident #034..

PLEASE NOTE: This area of non-compliance was identified during a CIS inspection #020943-18, conducted concurrently during the RQI.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issue was a level 2 as it related to nine out of twenty-six residents reviewed. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA that included:

• Compliance order (CO) #001 issued July 11, 2016, with a compliance due date of September 15, 2016 (A1) (2016_250511_0006);
• Compliance order #001 complied April 20, 2017, (2017_577611_0008) for CO #001 issued July 11, 2016, with a compliance due date of September 15, 2016 (A1) (2016_250511_0006);
• Voluntary Plan of Correction (VPC) issued August 21, 2017, (2017_575214_0010)

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

(682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 28, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 24th day of April, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by CATHY FEDIASH (214) - (A1)

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

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