Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 21, 2017 | 2017_646618_0015 | 036200-15, 008667-16, 008689-16, 018052-16, 019634-16, 027016-16, 027221-16, 027614-16, 028805-16, 031546-16, 033218-16, 000831-17, 002092-17, 002149-17, 003210-17, 003503-17, 006442-17, 008466-17, 008484-17, 011200-17, 011326-17, 015008-17 | Critical Incident System |

### Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

WESTSIDE
1145 Albion Road Rexdale ON M9V 4J7

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

CECILIA FULTON (618), GORDANA KRSTEVSKA (600), SLAVICA VUCKO (210), THERESA BERDOE-YOUNG (596)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, July 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, and 20th 2017.**

**The following Critical Incident Intake Logs were inspected during this inspection:036200-15, 008667-16, 008689-16, 018052-16, 019634-16, 027016-16, 027221-16, 027614-16, 028805-16, 031546-16, 033218-16, 000831-17, 002092-17, 002149-17, 003210-17, 003503-17, 006442-17, 008466-17, 008484-17, 011200-17, 011326-17, 015008-17.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal support workers ( PSW), Dietary Aide, Resident Care co-ordinator, Residents and Substitute Decision Makers (SDM).**

**During the course of the inspection, the inspector(s) observed the provision of resident care including medication administration, observed staff to resident and resident to resident interactions, and reviewed health records, staff training records, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

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

**14 WN(s)**
**3 VPC(s)**
**3 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to protect residents from abuse by anyone.

For the purpose of the definition of abuse, physical abuse" in subsection 2 (1) of the O. Reg. 79/10, means the use of physical force by anyone other than a resident that causes physical injury or pain.

1. This inspection was initiated to inspect items identified a Critical Incident report (CIR), dated in 2016, related to an alleged staff to resident incident of abuse.

Interview with PSW #136 revealed that on an identified date in 2016, PSW #136 observed PSW #135 trying to adjust resident #001 into position at the dining table. When PSW #135 tried to push resident #001 into position at the table, he/she was having trouble getting the resident in their wheelchair into place. Resident #001 was saying "no", because the leg of the table was hitting him/her. PSW #136 revealed that he/she told PSW #135 that you are hurting the resident. Resident #001 then raised his/her hands to indicate for PSW #135 to get away from him/her, to which PSW #135 responded to resident very negatively. Then PSW #135 took resident #001's hands and moved his arms and made him/her hit him/her self.

PSW #136 revealed that there was a co-resident at the table who objected and told PSW #135 to stop.

PSW #135 was not available for interview during this inspection.

Interview with DOC confirmed that PSW #135 had a disciplinary history related to a previous resident incident, and the DOC stated that the home's investigation confirmed that this incident was abuse. [s. 19. (1)]

2. This inspection was initiated to inspect items identified in a CIR dated in 2016, related to resident to resident abuse.

Resident #009 was found by staff in resident #008's room, and resident #008 was exhibiting identified behaviours directed at #009.

A subsequent CIR was submitted to the MOHLTC by the home reporting that on an identified date in 2017, staff observed that resident #008 demonstrated identified behaviours directed at resident #009 in the hallway. When staff asked the resident why he/she did that, he/she left the area quickly.

Record review of resident #008's and resident #009's written plan of care revealed that both residents exhibited responsive behaviours. Interventions to monitor both resident's behaviours were included in their plans of care.

Interview with resident #008 revealed that last year resident #009 used to come into his/her room and he/she would demonstrate behaviours directed at him/her and he/she would accept and reciprocate. Resident #008 admitted that in on an identified date in 2016, he/she demonstrated the identified behaviours towards resident #009 and he/she did not stop him/her. Resident #008 reported that on an identified date in 2017, resident #009 was in the hallway passing by him/her when he/she directed an identified behaviour to them. During investigation of this incident resident #008 admitted that it was stupid to do it again and he/she had forgotten not to do it, and has never done it again. After this day, anytime resident #009 came into the lounge and tried to talk to him/her, he/she did not respond and then the resident would leave.

Interview with resident #009 revealed that resident #008 demonstrated the identified behaviour to him/her and he/she could not recall ever demonstrating the identified behaviour towards resident #009 or going to resident #009's room. The resident stated that he/she did not like it and it was not the first time it happened, he/she did not tell anyone before.

Interview with PSW #123 revealed that on an identified date in 2016, he/she went into resident #008's room and saw resident #008 demonstrating the identified behaviour towards resident #009 while sitting in his/her chair. Resident #009 was standing by the window looking out. The PSW reported calling for the nurse who attended, and the two residents were separated. It was the first time he/she had seen resident #009 in resident

#008's room.

Interview with RN #133 revealed that he/she was called into resident #008's room by PSW #123 on an identified date in 2016, and saw resident #008 demonstrating the identified behaviour towards resident #009.

Interview with PSW #137 revealed that he/she was in the hallway on an identified date in 2017, when he/she observed resident #008 demonstrate the identified behaviour towards resident #009 as he/she passed by in his/her wheelchair. The PSW reported that he/she asked resident #008 why he/she did that and resident #008 just raised both hands in the air. The two residents are monitored and kept separated now. The PSW stated that resident #009 was abused by resident #008.

During this inspection the inspector observed resident #009 demonstrating an identified behaviour.

According to PSW #139 resident #009 used to go into resident #008's room but does not do it anymore. Staff have implemented interventions to manage the resident #009's identified behaviour.

According to PSW#142 resident #009 continues to demonstrate identified behaviours.

Interview with PSW #142, RN #131, and the DOC revealed that identified dates in 2016, and 2017, resident #008 demonstrated inappropriate behaviour towards resident #009. [s. 19. (1)]

3. This inspection was initiated to inspect items identified in a CIR dated in 2017, related to resident to resident abuse.

Record review revealed that on an identified date in 2017 resident #010 followed resident #011 into the elevator and was found to be touching resident #011 inappropriately.

Interview with registered staff #113 revealed that he/she had become aware that resident #010 was demonstrating behaviours directed at resident #011 and that he/she was monitoring resident #010 for these behaviours. Staff #113 revealed that on an identified date in 2017, he/she observed resident #010 follow resident #011 into the elevator. He/she immediately went and opened the elevator door to discover that resident #010 was exhibiting the identified behaviour towards resident #011.

Registered staff #113 revealed that he/she removed resident #011 from the elevator and the resident did not appear to have a reaction to the incident. Staff #113 conducted a head to toe assessment of resident #011 which did not reveal any injury.

Record review revealed a progress note dated in 2017, which stated that resident #010 was observed to be demonstrating identified behaviours towards resident #011.

Record review further revealed that resident #010 has a history of identified behaviours toward co-residents on four identified dates in 2016. These incidents occurred on a different home area to where the resident currently resides.

Interview with PSW #151 revealed that he/she was aware that resident #010 had exhibited some identified behaviours on his/her previous home area, but PSW #151 was not aware of any issues between resident #011 and #010 until after the date of the incident identified above.

Interview with staff #113 revealed that they were aware that resident #010 had exhibited these behaviours on his/her previous home areas, but was not aware of resident #010's extensive prior history of this behaviour and that there were no interventions in place to prevent resident #010 exhibiting these behaviours.

Interview with DOC confirmed that there was no monitoring of resident #010 when he/she was moved to the new home area. The DOC confirmed that when the behaviours were identified on the date in 2017, interventions should have been implemented in the plan of care to monitor the resident more effectively and as a result resident #011 was not protected from abuse. [s. 19. (1)]

4. The licensee has failed to ensure that residents were protected from abuse by staff in the home.

This inspection was initiated to inspect items identified in a CIR dated in 2017, relating to an allegation of staff to resident abuse.

Interview with resident #005 revealed that one occasion when staff #125 was providing his/her care she made an inappropriate comment using profanity to describe a resident's body part. The resident revealed that there had been previous incidents when he/she felt this staff member had not treated him/her respectfully, but the resident could not recall

exact incidents. The resident revealed that the incidents built up on him/her and made him/her feel very upset. The resident identified the treatment as belittling.

Interview with staff #125 revealed that while he/she was providing care to resident #005, he/she had spoken rudely to the resident. Staff #125 revealed that they had said this as a result of the resident speaking rudely that morning and being in a bad mood. Staff #125 confirmed that what he/she had said was not very respectful to the resident and that he/she should have handled the situation differently.

Interview with the DOC confirmed that the interaction from staff to the resident was not respectful.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2016_344586_0007 dated April1, 2016 related to the Long-Term Care Homes Act, 2007. [s. 19. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

This inspection was initiated to inspect items identified in a CIR dated in 2016, related to a fall with injury which resulted in a significant change in the resident's health status.

A review of resident #013's clinical record revealed the resident was admitted on an identified date in 2016. A review of the fall incident record revealed the resident had 8 falls within 6 months of admission. The initial fall risk assessment, conducted by registered staff #100 and the Physiotherapist (PT) revealed the resident was at high risk for falls.

A review of resident #013's written plan of care, created on an identified date in 2016, revealed fall prevention interventions. Further interventions were implemented on a later date in 2016.

Interview with registered staff #100 revealed when a resident is identified as being at

high risk for falls it is responsibility the of all nursing staff to create and implement interventions for falls prevention and update the written care plan.

Interview with DOC confirmed when resident #013 was admitted and assessed to be at high risk for falls, the interventions for fall prevention should have been included in the written plan of care but were not there until one month after the admission. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

This inspection was initiated to inspect items identified in Critical Incident Report dated 2017, regarding an improper transfer which resulted in injury.

Review of the resident's written plan of care revealed that resident #017 needed support for transfer. The goal identified in the plan of care was to maintain current level of self-performance for transferring through next review. Intervention to achieve this focus was for the staff to use a mechanical lift and two staff to provide full support for transfers. The plan of care did not identify the type of mechanical lift which was to be used.

Interview with PSW # 124 revealed that he/she had transferred the resident using an identified lift and with the assistance of another PSW and that during this transfer the resident sustained an injury.

PSW #124 revealed that the written plan of care did not specify the type of lift that was to be used for this resident's transfer.

Review of the home's surveillance video tape from the date in question, revealed the staff entering the resident's room with the sit to stand lift, not the Hoyer lift and that no other staff entered the room to assist him/her.

Interview with the DOC confirmed that the resident required an identified lift for transfer and the plan of care should set clear direction as for what type of lift to be used for this resident. [s. 6. (1) (c)]

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

This inspection was initiated to inspect items identified in a CIR dated 2017, regarding a

resident injury which was discovered on a prior date the same year. In the course of inspecting, the inspector identified issues related the resident's plan of care.

Review of resident #018's plan of care revealed that the resident had been identified to be at high risk for falls. The goal identified in the written plan of care was to minimize the risk of injury through to the next review and the resident will experience reduced number of falls. Interventions were identified in the written plan of care.

Resident #018 was observed by the inspector on 7 occasions during this inspection. These observations revealed that the interventions identified in the written plan of care were not being followed.

Interview with PSW #156 revealed that the resident was identified for risk of fall and was able to identify the fall prevention interventions.

Interview with RPN #109, confirmed that the interventions as identified in the written plan of care should have been followed. He/she further confirmed that the staff did not follow the resident plan of care when they did not follow the identified interventions. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

This inspection was initiated to inspect items identified in a CIR dated in 2017, related to an injury which resulted in a significant change in the resident health status.

Review of resident #018's progress notes revealed that on an identified date in 2017, PSW #156 reported to RPN #109 that the resident had an injury to an identified body part. The RPN conducted an assessment which confirmed the injury. The physician was notified and confirmed the injury with an X-ray. The home investigation was unable to identify the cause of the injury.

Review of a resident Minimum Data Set (MDS) assessment dated in 2017, revealed resident #018 needed total assistance by two staff for bed mobility.

Review of the resident written plan of care revealed that resident #018 needed extensive assistance of one staff for bed mobility. The resident had been identified to be at high risk for falls. Fall prevention interventions and sleep strategies were identified in the residents plan of care.

Inspector observations conducted during this inspection found the resident in bed. The observation also revealed that the interventions identified in the plan of care were not being followed.

Interview with PSW #156 and RPN #109 revealed that resident #018 needed total assistance by two staff to assist with bed mobility due to the above mentioned injury. He/she further stated that because of the injury the resident's care needs had changed. They also confirmed that the resident was at risk for fall and fall prevention interventions should have been followed.

Interview with Nurse Manager (NM) #165 revealed that resident #018's condition had changed after the incident and the staff should review and revise the resident's written plan of care to reflect the resident's changed needs.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2016_344586_0007 dated April1, 2016 related to the Long-Term Care Homes Act. [s. 6. (10) (b)]

***Additional Required Actions:***

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

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

**Findings/Faits saillants :**

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

This inspection was initiated to inspect items identified in a CIR dated 2017, regarding an injury that the resident #017 sustained on an identified date in 2017, during a transfer.

Review of the resident's written plan of care revealed that resident #017 needed support for transfer. The goal was to maintain current level of self-performance for transferring through next review. Intervention for this focus was for the staff to use a mechanical lift and two staff to provide full support for transfer.

Interview with PSW #124 and #125 was conducted on the same day when the incident happened.

Interview with PSW #124 revealed that on an identified date in 2017, while setting up resident #017 for transferring with an identified lift and assistance of PSW #125, the resident accidentally hit an identified body part with a bar of the lift. PSW #124 and #125 both provided the inspector their recollections of what occurred to cause this injury, however their recollections were not consistent.

Review of the home investigation record revealed that PSW #125 had submitted a written statement to the DOC confirming that he/she did not assist PSW #124 for transferring resident #017 when the resident sustained injury. Further review of the home investigation record indicated that on the identified date and time of the incident a home videotape showed PSW #124 walking in resident #017's room with a lift by him/herself. No other staff entered the room.

Interview with DOC confirmed staff used unsafe transferring device and technique with resident #017.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Voluntary plan of Correction (VPC) issued in inspection #2016_378116_0008 dated March 9, 2016, related to the Long-Term Care Homes Act. [s. 36.]

***Additional Required Actions:***

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

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**WN #4: 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:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that they have fully respected and promoted every resident's right to be treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity.

This inspection was initiated to inspect items identified a CIR relating to an allegation of staff to resident abuse.

Review of the home's surveillance video tape on an identified date in 2017, revealed that resident #025 was in his/her wheelchair at the entrance to his/her room. Resident #025 was observed to be attempting to enter his/her room. On the video a persons hand can be seen coming from inside of the room and touching the right arm of the resident's wheelchair appearing to be preventing the resident access to the room. The video further reveals a staff member, identified as PSW #110 push the resident's wheelchair back and to the right. The wheelchair turned 180 degrees and rolled to the wall across the hallway.

The resident was observed on many occasions during the inspection mobilizing in his/her

wheelchair in the area around his/her room.

Interview with volunteer #112 who had witnessed the incident revealed that when he/she walked passed the room where resident #025 was attempting to enter, he/she heard staff #110 say to the resident to either come in the room or go out because he/she had to close the door. The visitor did not see staff #110 push the resident's wheelchair, but he/she did see the resident immediately after they were pushed into the hallway. Volunteer #122 revealed that the resident did not appear or express that they had been injured, but did express shock and surprise that they had been pushed this way.

Interview with staff #110 revealed that he/she had attempted to prevent resident #025 from entering the room because the entrance area to the room was crowded with some equipment and another resident waiting to be assisted to the bathroom and another resident in the bathroom. Staff #110 revealed that the resident in the bathroom was standing up and losing his/her balance and that staff #110 reacted quickly to get resident #025 out of the way so that he/she could attend to the resident in the bathroom. Staff #110 confirmed that he/she had pushed and turned resident #025's wheelchair out in the direction of the hallway and closed the door.

Interview with DOC confirmed that the way the resident was pushed out of the way was not respectful to the resident. [s. 3. (1) 1.]

2. This inspection was initiated to inspect items identified in CIR dated 2017, relating to an allegation of staff to resident abuse.

Interview with resident #004 revealed that while providing care to him/her, PSW #132 told him/her to shut up and the resident also demonstrated that PSW #132 touched him on his back. Resident #004 revealed that he/she was not hurt or injured in this encounter but that he/she felt disrespected being told to shut up.

Interview with PSW #132 revealed that this incident occurred while he/she was providing care to the resident and tying the resident's gown. PSW #132 stated that he/she was behind the resident and that the resident was talking to him/her but the PSW was not understanding what was being said. PSW #132 stated he/she was reaching around to find the ties and told the resident to be quiet. The resident then turned around quickly and PSW #132 stated that his/her hand touched the resident's back as a result of the resident's movement.

Interview with registered staff #121, stated that during an interview shortly after the incident the resident revealed that he/she was not hurt, but that he/she felt disrespected being told to shut up.

Interview with staff #163 revealed that he/she interviewed the resident shortly after the incident and that the resident was upset about how the PSW had spoken to him/her. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the rights of every resident to be protected from abuse were fully respected and promoted.

This inspection was initiated to inspect items identified in CIR dated in 2017, related to an alleged incident of staff to resident abuse.

Interview with resident #007 revealed that a few months ago at the nursing station, RPN #105 screamed at him/her but he/she could not remember exactly what the staff said. The resident reported that he/she did not feel good about the way the nurse spoke to him/her and that RPN #105 speaks loudly to other residents also. Resident #007 stated that after the management spoke with the nurse about the incident he/she speaks to him calmly now without yelling.

Record review of the home's investigation notes and Customer Service Response (CSR) form revealed on an identified date in 2017, the resident was not feeling well and requested his/her morning medication from RPN #105. RPN #105 was administering medications to other residents in front of the nursing station and told resident #007 not to bother him/her while he/she was giving medication. The resident reported that it hurt his/her feelings.

Interview with RPN #105 revealed that on the above mentioned morning the resident came to him/her twice while he/she was administering residents' medication asking if he/she forgives him/her. RPN stated that the resident had not mentioned that he/she was not feeling well, but just kept asking the nurse if he/she forgives him/her. RPN #105 revealed that he/she became frustrated by this resident and agreed that her voice is usually loud when he/she speaks.

According to the ADOC who followed up with the resident and the RPN, the RPN should have spoken calmly to the resident and explained that he/she was busy administering medications and would be with him/her shortly. The ADOC stated that the RPN was

neglectful towards the resident when all he/she wanted was his/her medication. The RPN was retrained on resident abuse and neglect.

Interview with the DOC revealed that the home's investigation concluded that RPN #107 was verbally abusive to resident #007, and he/she was disciplined and received retraining on resident abuse and neglect. [s. 3. (1) 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 residents are treated resident #025's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted., to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

This inspection was initiated to inspect items identified in CIR dated in 2017, related to a fall which resulted in injury.

A review of resident #014 clinical record revealed the resident was identified as a high risk for falls and used an identified mobility aid. Interview with the resident revealed that the reason for the fall on an identified date in 2017, was because a cleaning mop was positioned in front of the door, between the rail and the wall and the resident did not have space where to pass as there was also a linen cart on the left side of the door and another resident in wheelchair blocking the hallway.

Interview with house keeping staff #106 revealed that on that morning he/she had left the mop in front of resident #014's room while he/she was cleaning other areas on the unit. When he/she arrived at the scene, the linen cart that was usually placed in the hallway, beside the wall between the doors, was moved by the resident in the middle of the hallway. The resident was laying on the floor with the stick of the cleaning mop between his/her legs.

Interview with Environmental Services Manager (ESM) staff #108 revealed that the home investigated the incident and identified the possible reasons for the fall as the resident not using the walker while ambulating, an unattended mop being left in front of the resident's door and because the wheels of the linen cart sticking out causing a tripping hazard.

During the course of this inspection the inspector made many observations of hallways cluttered with various equipment, storage carts and laundry carts and that the hallways were often only passable by one resident at a time. [s. 5.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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**WN #6: 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 has failed to ensure that any policy instituted or otherwise put in place was complied with.

This inspection was initiated to inspect items identified in a CIR dated in 2016, related to the administration of an expired product.

Review of the home's medication incident revealed that an expired medical product was administered to resident #021. The incident report identified a causative factor as being lack of quality control or independent check systems were identified .

Record review of the home's investigation notes revealed RPN #100 stated that he/she had administered the expired product on an identified date in 2016, and that he/she had gotten the product from the stock room along with other supplies.

Record review revealed a physician's order for the treatment on an identified date in 2016.

Record review of the resident #021's eMAR revealed staff signed off that the product was administered as ordered.

Record review of the home's policy titled LTC- Medication Administration, index CARE13-010.01, reviewed date July 31, 2016, indicated that expired medication will not be administered and must be returned to the pharmacy provider as soon as possible.

Interview with RPN #100 reported he/she took the identified product from the medication room and administered it to resident #021 as ordered. RPN #100 stated that he/she did not check the expiry date of the product before administering it, and that he/she should have checked it prior to administration.

Interview with the DOC revealed that after investigating the above mentioned medication error, the home concluded resident #021 was administered an expired medical product on an identified date in 2016.

The DOC stated that the Nurse Manager should have checked to ensure that the identified product was not expired before bringing them up to the unit, and that RPN #100 should also have checked before administering it to the resident. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any policy instituted or otherwise put in place was complied with, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

**Specifically failed to comply with the following:**

**s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the 24-hours admission care plan was based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator under section 44 of the Act.

A review of resident #013's clinical record revealed the resident was admitted on an identified date in 2016, and the initial resident admission assessment/plan of care form was found to be incomplete in all sections except the activity pursuit patterns. A review of the 24 hours assessment form in Point Click Care (PCC) revealed the resident was assessed for methods of transfer, lift, ambulation and repositioning.

Interview with DOC revealed that the initial care plan should be created within 24 hours of admission and confirmed that the same was not created for resident #013. [s. 24. (4)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care**

**Specifically failed to comply with the following:**

**s. 25. (1) Every licensee of a long-term care home shall ensure that,**
**(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).**
**(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure the initial plan of care was developed within 21 days of the resident's admission.

A review of resident #013's clinical record indicated the resident was admitted on an identified date in 2016, and the initial plan of care for bed mobility, dressing, mobility, toileting, hygiene, were created on an identified date in 2016 beyond the 21 days as required.

Interview with RAI MDS Coordinator Staff #117 revealed the initial plan of care should be created in 21 days of the admission and confirmed the above mentioned sections of resident #013's initial plan of care were not created until 29 days after the resident's admission. [s. 25. (1) (b)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language.

A review of resident #013's written plan of care including the section for activities revealed the resident has a language barrier. There were no interventions in the written plan of care which identified how staff should communicate with the resident. The post fall assessment on an identified date in 2016, indicated the resident had a fall and the registered staff was unable to determine how he/she fell because of a language barrier. The post fall assessment on an identified date in 2016, indicated the nurse was not able to assess the resident pain because the resident was not able to verbalize.

During an interview with RN #100 revealed she was able to communicate with resident #013 because she spoke the same language as the resident but she was not sure how other staff communicated with the resident.

Interview with DOC indicated that two to three months ago the home started implementing other methods of communicating with some residents, however resident #013's care plan did not have strategies how staff were to communicate with the resident. [s. 26. (3) 3.]

2. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk for falls and other special needs.

This inspection was initiated to inspect items identified in a Critical Incident Report dated in 2017, relating to a resident fall.

Record review revealed that resident #015 was admitted at the home on an identified date in 2017. Community Care Access Center (CCAC) admission assessment revealed the resident's cognitive and ambulation status and identified that he/she was at danger for falls. The CCAC documents further revealed that the resident had recently been discharged from hospital following multiple falls, that he/she did not use his/her cane and that he/she had had several falls in the washroom of their private home as well as a fall while in the hospital.

A review of the 24 hour plan of care revealed documentation that resident #015 had one fall in last three months. A review of the Falls Risk Assessment Tool from an identified date shortly after the resident's admission, revealed the resident was low risk for falls. A review of the initial progress note revealed no indication that the resident had a history of previous falls or what ambulation aids were being used at home. Interview with RN #102 confirmed there were no interventions to prevent falls in the initial plan of care.

A review of resident #015's falls record revealed the resident had a fall on an identified date in 2017, and was transferred to hospital for an injury to an identified body area which resulted in transfer to the hospital. Interview with PSW #104 revealed he/she found the resident sitting on the floor suspected that the resident had tripped because of their footwear. Interview with PSW #104 revealed no awareness that resident #015 had a history of previous falls, or that he/she was at risk for falls or that there were any interventions to prevent falls.

A review of the admission physiotherapist (PT) assessment, revealed resident #015 was at low risk for falls. Interview with PT revealed unawareness that resident #015 had a history of falls or that the resident used an identified mobility aid before admission. A PT assessment which occurred after the resident had incurred two falls, revealed that the nursing staff requested new modified footwear from the son, educated the resident to have less clutter in the room, that the room to be lighted always and resident was encouraged to ask for help when needed.

Interview with DOC indicated if a resident is admitted in the home with a history of falls in the last 90 days interventions to prevent falls should be created in the plan of care, which was not a case with resident #015's plan of care. [s. 26. (3) 10.]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has 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.

This inspection was initiated to inspect items identified in a CIR dated in 2016, related to a resident fall which resulted in hospitalization and a significant change in the resident's health status.

A review of resident #013 clinical record revealed the resident was admitted on an identified date in 2016. A review of the fall incident record revealed the resident had 8 falls with in an identified four month period in 2016. The initial fall risk assessment by registered staff #100 and the Physiotherapist (PT) revealed the resident was at high risk for falls.

A review of a physician's order written on an identified date in 2016, revealed that the resident was prescribed an identified therapy. Review of the electronic medication administration record (eMAR) revealed the physician's order for this therapy was not transcribed in the eMAR.

A review of progress notes revealed that on an identified dates in 2016, the resident was experiencing symptoms and had incurred falls. Physician assessment of the resident's symptoms revealed that symptoms were improved when the identified therapy was administered as prescribed. A post fall assessment record following one of the identified falls did not indicate if the resident was monitored for the effectiveness of the identified prescribed therapy. The resident was found to have sustained an identified injury with this fall.

Interview with DOC confirmed that the prescribed therapy, including indications for use should have been included in the eMar and it had not been. [s. 30. (2)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (1) The pain management program must, at a minimum, provide for the following:**
**1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).**
**2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).**
**3. Comfort care measures. O. Reg. 79/10, s. 52 (1).**
**4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the pain management program must, at a minimum, provide for the monitoring of the residents' responses to, and the effectiveness of, the pain management strategies.

Review of a CIR dated in 2015, revealed that resident #019 sustained injuries to an identified body area after falls he/she had on identified dates in 2015.

Review of the medication administration record (eMAR) and doctors order for an identified date in 2015, revealed that resident #019 had been receiving an identified medication for pain relief.

Review of the progress notes revealed that on identified dates the identified medication was administered as directed.

Further review of resident #019's progress notes failed to confirm that the staff had monitored and documented the resident's response and the effectiveness of the medication he/she received on the identified dates.

Interviews with RPN's #105 and #147 confirmed that they had not monitored and documented the effect of the medication given as each of them expected the upcoming shift to document the effect of the medication.

Interview with the Director of Care (DOC) confirmed the staff was expected to monitor and document the resident's response and the effect of the medication. [s. 52. (1)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident who demonstrated responsive behaviours.

Review of a CIR dated in 2017, reported that resident # 010 inappropriately touched resident #011.

Record review revealed that resident #011 had been observed exhibiting behaviour toward co-resident on identified dates in 2016, and was subsequently transferred to a new home area.

Record review revealed that behaviours were not identified in the resident's plan of care and there were no interventions in place when he/she was transferred to the new home area.

A progress note written on an identified date in 2016, revealed that staff #113 had become aware that resident #011 was exhibiting the identified behaviours towards resident #010.

Interview with staff #113 revealed that he/she could not recall if this information had been

communicated to other staff. Staff #113 did confirm that there was no documentation that any interventions were implemented to monitor resident #011's behaviour.

Interview with PSW #151 revealed that he/she was not aware that resident #011 was exhibiting behaviours towards resident #010 until after the documented incident.

Interview with DOC confirmed that there were no interventions in place to monitor resident #011's behaviours. [s. 53. (4) (b)]

2. This inspection was initiated to inspect items identified in CIR dated in 2016, regarding resident to resident abuse and responsive behaviours.

Record review revealed that on an identified date in 2016, resident #009 was found by staff in resident #008's room, and resident #009 was found exhibiting inappropriate behaviours towards resident #008.

A subsequent CIR reported that on another identified date in 2017, staff observed that resident #008 inappropriately touched resident #009 in the hallway. When staff asked the resident why he/she did that, he/she left the area quickly.

The Dementia Observation System (DOS) form was initiated for resident #008 on an identified date in 2016. These observations should be made and documented on all shifts for seven days.

Record review of resident #008's DOS monitoring record was incomplete for the time period under observation.

Interviews with PSWs #140 and #139 who worked day and evening shifts on with missing documentation revealed that they monitored resident #008 for responsive behaviours throughout their shifts, and could not remember why they did not document on the resident's DOS form.

The DOC stated that according to the home's policy titled Dementia Care Program, index CARE3-P10, effective date August 31, 2016, and the home's expectations, the above mentioned PSW staff should have documented resident #008's responsive behaviours on all times and dates of the observation period. [s. 53. (4) (c)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to inform the Director no later than one business day after the occurrence of the incident of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Review of a CIR dated in 2017, reported an incident which resulted in resident injury and hospitalization which occurred on an identified date in 2017.

Interview with the DOC confirmed that he/she was aware that the home should inform the Director no later than one business day after the occurrence of an incident, but he/she was not aware of this incident as he/she was not around at the time when the incident happened. The DOC confirmed that the report had not been submitted in the time frame required. [s. 107. (3)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records**

**Specifically failed to comply with the following:**

**s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the records of every former resident of the home were retained by the licensee for at least 10 years after the resident was discharged from the home.

Review of the documentation revealed that the Ministry of Health and Long Term Care (MOHLTC) had received a call on an identified date in 2016, reporting a suspected physical abuse of resident #050. A review of the MOHLTC's incident report revealed that the Acting Nurse Manager called the MOHLTC to report an injury to an identified body area.

A review of resident #050'sclinical records revealed the resident had been discharged from the home on an identified date in 2017.

Interview with NM #120 confirmed that the resident was discharged on an identified date in 2017, and that he/she recalled reading the above mentioned incident report. The NM further confirmed that the incident report should be kept in the resident's archived records in the home, but it was not. [s. 233. (1)]

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**Issued on this 26th day of October, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | CECILIA FULTON (618), GORDANA KRSTEVSKA (600), SLAVICA VUCKO (210), THERESA BERDOE-YOUNG (596) |
| **Inspection No. / No de l'inspection :** | 2017_646618_0015 |
| **Log No. / No de registre :** | 036200-15, 008667-16, 008689-16, 018052-16, 019634-16, 027016-16, 027221-16, 027614-16, 028805-16, 031546-16, 033218-16, 000831-17, 002092-17, 002149-17, 003210-17, 003503-17, 006442-17, 008466-17, 008484-17, 011200-17, 011326-17, 015008-17 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 21, 2017 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000 |
| **LTC Home / Foyer de SLD :** | WESTSIDE<br>1145 Albion Road, Rexdale, ON, M9V-4J7 |

Lydia Baksh

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Name of Administrator /**
**Nom de l'administratrice ou de l'administrateur :**

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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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 :**

1. Within 30 days of receiving this order, the Licensee shall conduct meeting(s) with all direct care.

The purpose of the meeting(s) are to:

a. Review and have staff demonstrate an understanding of the residents' right to be treated with courtesy and respect, and the definitions of abuse as defined in the LTCA , 2007, and their duty to protect residents from abuse.

b. Implement a schedule for regular Behavioural Support meetings, and maintain a written record of the discussion items and action plans identified in these meetings.

**Grounds / Motifs :**

1. 1. The licensee has failed to protect residents from abuse by anyone.

For the purpose of the definition of abuse, physical abuse" in subsection 2 (1) of the O. Reg. 79/10, means the use of physical force by anyone other than a resident that causes physical injury or pain.

1. This inspection was initiated to inspect items identified a Critical Incident report (CIR), dated in 2016, related to an alleged staff to resident incident of abuse.

Interview with PSW #136 revealed that on an identified date in 2016, PSW #136 observed PSW #135 trying to adjust resident #001 into position at the dining table. When PSW #135 tried to push resident #001 into position at the table,

he/she was having trouble getting the resident in their wheelchair into place. Resident #001 was saying "no", because the leg of the table was hitting him/her. PSW #136 revealed that he/she told PSW #135 that you are hurting the resident. Resident #001 then raised his/her hands to indicate for PSW #135 to get away from him/her, to which PSW #135 responded to resident very negatively. Then PSW #135 took resident #001's hands and moved his arms and made him/her hit him/her self.

PSW #136 revealed that there was a co-resident at the table who objected and told PSW #135 to stop.

PSW #135 was not available for interview during this inspection.

Interview with DOC confirmed that PSW #135 had a disciplinary history related to a previous resident incident, and the DOC stated that the home's investigation confirmed that this incident was abuse. [s. 19. (1)]

2. This inspection was initiated to inspect items identified in a CIR dated in 2016, related to resident to resident abuse.

Resident #009 was found by staff in resident #008's room, and resident #008 was exhibiting identified behaviours directed at #009.

A subsequent CIR was submitted to the MOHLTC by the home reporting that on an identified date in 2017, staff observed that resident #008 demonstrated identified behaviours directed at resident #009 in the hallway. When staff asked the resident why he/she did that, he/she left the area quickly.

Record review of resident #008's and resident #009's written plan of care revealed that both residents exhibited responsive behaviours. Interventions to monitor both resident's behaviours were included in their plans of care.

Interview with resident #008 revealed that last year resident #009 used to come into his/her room and he/she would demonstrate behaviours directed at him/her and he/she would accept and reciprocate. Resident #008 admitted that in on an identified date in 2016, he/she demonstrated the identified behaviours towards resident #009 and he/she did not stop him/her. Resident #008 reported that on an identified date in 2017, resident #009 was in the hallway passing by him/her when he/she directed an identified behaviour to them. During investigation of

this incident resident #008 admitted that it was stupid to do it again and he/she had forgotten not to do it, and has never done it again. After this day, anytime resident #009 came into the lounge and tried to talk to him/her, he/she did not respond and then the resident would leave.

Interview with resident #009 revealed that resident #008 demonstrated the identified behaviour to him/her and he/she could not recall ever demonstrating the identified behaviour towards resident #009 or going to resident #009's room. The resident stated that he/she did not like it and it was not the first time it happened, he/she did not tell anyone before.

Interview with PSW #123 revealed that on an identified date in 2016, he/she went into resident #008's room and saw resident #008 demonstrating the identified behaviour towards resident #009 while sitting in his/her chair. Resident #009 was standing by the window looking out. The PSW reported calling for the nurse who attended, and the two residents were separated. It was the first time he/she had seen resident #009 in resident #008's room.

Interview with RN #133 revealed that he/she was called into resident #008's room by PSW #123 on an identified date in 2016, and saw resident #008 demonstrating the identified behaviour towards resident #009.

Interview with PSW #137 revealed that he/she was in the hallway on an identified date in 2017, when he/she observed resident #008 demonstrate the identified behaviour towards resident #009 as he/she passed by in his/her wheelchair. The PSW reported that he/she asked resident #008 why he/she did that and resident #008 just raised both hands in the air. The two residents are monitored and kept separated now. The PSW stated that resident #009 was abused by resident #008.

During this inspection the inspector observed resident #009 demonstrating an identified behaviour.

According to PSW #139 resident #009 used to go into resident #008's room but does not do it anymore. Staff have implemented interventions to manage the resident #009's identified behaviour.

According to PSW#142 resident #009 continues to demonstrate identified behaviours.

Interview with PSW #142, RN #131, and the DOC revealed that identified dates in 2016, and 2017, resident #008 demonstrated inappropriate behaviour towards resident #009. [s. 19. (1)]

3. This inspection was initiated to inspect items identified in a CIR dated in 2017, related to resident to resident abuse.

Record review revealed that on an identified date in 2017 resident #010 followed resident #011 into the elevator and was found to be touching resident #011 inappropriately.

Interview with registered staff #113 revealed that he/she had become aware that resident #010 was demonstrating behaviours directed at resident #011 and that he/she was monitoring resident #010 for these behaviours. Staff #113 revealed that on an identified date in 2017, he/she observed resident #010 follow resident #011 into the elevator. He/she immediately went and opened the elevator door to discover that resident #010 was exhibiting the identified behaviour towards resident #011.

Registered staff #113 revealed that he/she removed resident #011 from the elevator and the resident did not appear to have a reaction to the incident. Staff #113 conducted a head to toe assessment of resident #011 which did not reveal any injury.

Record review revealed a progress note dated in 2017, which stated that resident #010 was observed to be demonstrating identified behaviours towards resident #011.

Record review further revealed that resident #010 has a history of identified behaviours toward co-residents on four identified dates in 2016. These incidents occurred on a different home area to where the resident currently resides.

Interview with PSW #151 revealed that he/she was aware that resident #010 had exhibited some identified behaviours on his/her previous home area, but PSW #151 was not aware of any issues between resident #011 and #010 until after the date of the incident identified above.

Interview with staff #113 revealed that they were aware that resident #010 had

exhibited these behaviours on his/her previous home areas, but was not aware of resident #010's extensive prior history of this behaviour and that there were no interventions in place to prevent resident #010 exhibiting these behaviours.

Interview with DOC confirmed that there was no monitoring of resident #010 when he/she was moved to the new home area. The DOC confirmed that when the behaviours were identified on the date in 2017, interventions should have been implemented in the plan of care to monitor the resident more effectively and as a result resident #011 was not protected from abuse. [s. 19. (1)]

4. The licensee has failed to ensure that residents were protected from abuse by staff in the home.

This inspection was initiated to inspect items identified in a CIR dated in 2017, relating to an allegation of staff to resident abuse.

Interview with resident #005 revealed that one occasion when staff #125 was providing his/her care she made an inappropriate comment using profanity to describe a resident's body part. The resident revealed that there had been previous incidents when he/she felt this staff member had not treated him/her respectfully, but the resident could not recall exact incidents. The resident revealed that the incidents built up on him/her and made him/her feel very upset. The resident identified the treatment as belittling.

Interview with staff #125 revealed that while he/she was providing care to resident #005, he/she had spoken rudely to the resident. Staff #125 revealed that they had said this as a result of the resident speaking rudely that morning and being in a bad mood. Staff #125 confirmed that what he/she had said was not very respectful to the resident and that he/she should have handled the situation differently.

Interview with the DOC confirmed that the interaction from staff to the resident was not respectful.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2016_344586_0007 dated April1, 2016 related to the Long-Term Care Homes Act, 2007. [s. 19. (1)] (618)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2017

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

**Order / Ordre :**

1. Within 30 days of receiving this order, the Licensee shall conduct meeting with all direct care.

The purpose of the meeting(s) are to:

a. Review the legislative requirements dealing with resident's plan of care, including but not limited to s. 6 (1) (c), s. 6. (7) and s. 6. (10) (b), and have the staff demonstrate an understanding of the requirements.
b. Discuss each team members role and responsibilities in developing the written plan of care, reviewing and revising the plan of care when the resident's care needs change and providing care as specified in the plan of care.
c.. Maintain a record of who attended the meeting(s), when the meeting(s) were held and what information was provided at the meeting(s).

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

This inspection was initiated to inspect items identified in a CIR dated in 2016, related to a fall with injury which resulted in a significant change in the resident's health status.

A review of resident #013's clinical record revealed the resident was admitted on an identified date in 2016. A review of the fall incident record revealed the

resident had 8 falls within 6 months of admission. The initial fall risk assessment, conducted by registered staff #100 and the Physiotherapist (PT) revealed the resident was at high risk for falls.

A review of resident #013's written plan of care, created on an identified date in 2016, revealed fall prevention interventions. Further interventions were implemented on a later date in 2016.

Interview with registered staff #100 revealed when a resident is identified as being at high risk for falls it is responsibility the of all nursing staff to create and implement interventions for falls prevention and update the written care plan.

Interview with DOC confirmed when resident #013 was admitted and assessed to be at high risk for falls, the interventions for fall prevention should have been included in the written plan of care but were not there until one month after the admission. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

This inspection was initiated to inspect items identified in Critical Incident Report dated 2017, regarding an improper transfer which resulted in injury.

Review of the resident's written plan of care revealed that resident #017 needed support for transfer. The goal identified in the plan of care was to maintain current level of self-performance for transferring through next review. Intervention to achieve this focus was for the staff to use a mechanical lift and two staff to provide full support for transfers. The plan of care did not identify the type of mechanical lift which was to be used.

Interview with PSW # 124 revealed that he/she had transferred the resident using an identified lift and with the assistance of another PSW and that during this transfer the resident sustained an injury.

PSW #124 revealed that the written plan of care did not specify the type of lift that was to be used for this resident's transfer.

Review of the home's surveillance video tape from the date in question, revealed the staff entering the resident's room with the sit to stand lift, not the Hoyer lift

and that no other staff entered the room to assist him/her.

Interview with the DOC confirmed that the resident required an identified lift for transfer and the plan of care should set clear direction as for what type of lift to be used for this resident. [s. 6. (1) (c)]

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

This inspection was initiated to inspect items identified in a CIR dated 2017, regarding a resident injury which was discovered on a prior date the same year. In the course of inspecting, the inspector identified issues related the resident's plan of care.

Review of resident #018's plan of care revealed that the resident had been identified to be at high risk for falls. The goal identified in the written plan of care was to minimize the risk of injury through to the next review and the resident will experience reduced number of falls. Interventions were identified in the written plan of care.

Resident #018 was observed by the inspector on 7 occasions during this inspection. These observations revealed that the interventions identified in the written plan of care were not being followed.

Interview with PSW #156 revealed that the resident was identified for risk of fall and was able to identify the fall prevention interventions.

Interview with RPN #109, confirmed that the interventions as identified in the written plan of care should have been followed. He/she further confirmed that the staff did not follow the resident plan of care when they did not follow the identified interventions. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

This inspection was initiated to inspect items identified in a CIR dated in 2017, related to an injury which resulted in a significant change in the resident health status.

Review of resident #018's progress notes revealed that on an identified date in 2017, PSW #156 reported to RPN #109 that the resident had an injury to an identified body part. The RPN conducted an assessment which confirmed the injury. The physician was notified and confirmed the injury with an X-ray. The home investigation was unable to identify the cause of the injury.

Review of a resident Minimum Data Set (MDS) assessment dated in 2017, revealed resident #018 needed total assistance by two staff for bed mobility.

Review of the resident written plan of care revealed that resident #018 needed extensive assistance of one staff for bed mobility. The resident had been identified to be at high risk for falls. Fall prevention interventions and sleep strategies were identified in the residents plan of care.

Inspector observations conducted during this inspection found the resident in bed. The observation also revealed that the interventions identified in the plan of care were not being followed.

Interview with PSW #156 and RPN #109 revealed that resident #018 needed total assistance by two staff to assist with bed mobility due to the above mentioned injury. He/she further stated that because of the injury the resident's care needs had changed. They also confirmed that the resident was at risk for fall and fall prevention interventions should have been followed.

Interview with Nurse Manager (NM) #165 revealed that resident #018's condition had changed after the incident and the staff should review and revise the resident's written plan of care to reflect the resident's changed needs.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2016_344586_0007 dated April1, 2016 related to the Long-Term Care Homes Act. [s. 6. (10) (b)] (210)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2017

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

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.

**Order / Ordre :**

1. Within 30 days of receiving this order, the Licensee shall conduct meeting with all direct care.

The purpose of the meeting(s) are to:

a. Review and have staff demonstrate understanding of the importance of safe positioning and transferring techniques, and following the resident's plan of care as it relates to safe positioning and transferring.
b. Review safe transferring and positioning of residents and the safe use of transfer devices.
c. Maintain a record of who attended the meeting, when the meeting(s) were held and what information was provided at the meeting(s).

**Grounds / Motifs :**

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

This inspection was initiated to inspect items identified in a CIR dated 2017, regarding an injury that the resident #017 sustained on an identified date in 2017, during a transfer.

Review of the resident's written plan of care revealed that resident #017 needed support for transfer. The goal was to maintain current level of self-performance for transferring through next review. Intervention for this focus was for the staff to use a mechanical lift and two staff to provide full support for transfer.

Interview with PSW #124 and #125 was conducted on the same day when the incident happened.

Interview with PSW #124 revealed that on an identified date in 2017, while setting up resident #017 for transferring with an identified lift and assistance of PSW #125, the resident accidentally hit an identified body part with a bar of the lift. PSW #124 and #125 both provided the inspector their recollections of what occurred to cause this injury, however their recollections were not consistent.

Review of the home investigation record revealed that PSW #125 had submitted a written statement to the DOC confirming that he/she did not assist PSW #124 for transferring resident #017 when the resident sustained injury. Further review of the home investigation record indicated that on the identified date and time of the incident a home videotape showed PSW #124 walking in resident #017's room with a lift by him/herself. No other staff entered the room.

Interview with DOC confirmed staff used unsafe transferring device and technique with resident #017.

The severity of the non-compliance and the severity of the harm were actual. The scope of the non-compliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Voluntary plan of Correction (VPC) issued in inspection #2016_378116_0008 dated March 9, 2016, related to the Long-Term Care Homes Act. [s. 36.] (600)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 30, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

| | |
|---|---|
| À l'attention du/de la registrateur(e)<br>151, rue Bloor Ouest, 9e étage<br>Toronto ON M5S 2T5 | Directeur<br>a/s du coordonnateur/de la coordonnatrice en matière d'appels<br>Direction de l'inspection des foyers de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Toronto ON M5S 2B1<br>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 21st day of September, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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**Name of Inspector / Nom de l'inspecteur :** Cecilia Fulton

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