Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2015;	2015_200148_0016 (A1)	O-001968-15	Resident Quality Inspection

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

On July 28, 2015, Administrator provided written request by email to Inspector #148, to extend the complaince date, due to service provider's availability for maglock system installation.

Issued on this 29 day of July 2015 (A1)

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

Original report signed by the inspector.

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AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): May 19-22 and May 24-29, 2015, on site.

The Resident Quality Inspection included the following Critical Incident logs: O-001006-14, O-001457-14, O-001707-15, O-002009-15; Follow up log: O-001474-15; and Complaint logs: O-001154-14, O-001994-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Nursing Administrative Services Manager, Clinical Care Coordinator, Life Enrichment Coordinator, Nutritional Care Manager, Food Service Workers, Physiotherapist, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Wound Care Nurse, Personal Support Workers (PSW), Laundry Aid, Housekeeping Aid, Maintenance Employee, residents and family members.

In addition, the inspectors reviewed resident health care records including plans of care, assessment and monitoring data, along with nursing staffing patterns, meeting minutes from the resident and family councils and programs such as the home’s fall, medication, prevention of abuse, complaint and skin programs. Inspectors also observed meal service, resident care, staff/resident interaction and resident areas for cleanliness and repair.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
18 WN(s)
5 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 :

On January 5, 2015, Inspector #148 issued Compliance Order (CO) #001 under Inspection #2014_200148_0041. The inspection was conduced in November 2014 and related to two incidents of witnessed staff to resident abuse.

The grounds of the CO included compliance issues related to sections 20(1) and 20(2) of the Act and section 97 of the Regulations. The CO instructed the home to ensure all allegations of resident abuse and neglect are reported and investigated in accordance with the legislated requirements; to revise the policy to promote zero tolerance of abuse and neglect of residents to include an explanation of the duty under section 24 to make mandatory reports; to education of all staff related to the revised policy to promote zero tolerance of abuse and neglect of residents; and to develop a process to audit each investigation into allegations of resident abuse and neglect to ensure compliance with the legislation and to develop a written plan of corrective action to address any failures identified. The home was to have complied with section 19 of the Act by March 9 2015.

During this Resident Quality Inspection two Critical Incident reports were reviewed related to alleged staff to resident abuse (one of which occurred prior to January 2015), in addition to the follow up of CO #001 issued January 2015. (Log O-001474-15, O-001457-14 and O-002009-15).

On May 29, 2015, Inspector #148 discussed the CO of January 2015 and the most recent incident of alleged staff to resident abuse, with the home's Administrator. The Administrator reported that the licensee's policy to promote zero tolerance of abuse and neglect of residents had been updated in January 2015 and that all staff in the home had been provided with training on the updated policy. Inspector #148 was able to confirm the newly revised policy was dated January 2015 and that staff involved in the alleged staff to resident abuse reported had been provided with training on the abuse policy since January 2015. The Administrator reported that the home has implemented an audit tool, which he identified as the Mandatory Report Checklist. As it relates to the most recent incident, the Administrator noted that the checklist had been completed and no failures were identified.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to section 20(1) of the Act and WN #13 of this Inspection Report:

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

As identified, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

The policy includes the following: failure of an employee to report a suspected or witness incident of neglect or abuse shall be subject to disciplinary action; any person who has reasonable grounds to suspect abuse is obligated to report the information to the Home's Administrator or designate; a staff member who witnesses, suspects or hears about an act of abuse or neglect, shall report the incident to a direct manager, DOC or Administrator.

On a specified date, PSW #S126 was witnessed by PSW Student #S124 to use profanities and call Resident #53, disgusting during the provision of toileting care. No injury was sustained and the resident does not recall the events. On a morning two days after the incident, PSW Student #S124 reported the information to her preceptor at which time the home's management were made aware. The home began an investigation on the same date, which was concluded approximately 2 weeks later resulting in the termination of employment for PSW #S126.

On a specified date, PSW #S123 was witnessed by RPN #S120, to raise her voice and speak inappropriately to Resident #55. The resident reported that PSW #S123 had slapped him/her across the face and pulled at the resident's arm during assistance with a transfer, both causing the resident pain. The resident further reported that PSW #S123, had spoken to the resident inappropriately including telling him/her to shut up and that he/she was stupid. On the following morning, the resident reported the incident to PSW #S125 during care, in which PSW #S125 shared the information with the home's management. The home's DOC reported that the home began an investigation on the same day, which concluded one day later, resulting in the termination of employment for PSW #S123.

The home's DOC confirmed that all staff identified above were provided with orientation or annual training on the home's policy to promote zero tolerance of abuse

and neglect of residents, as appropriate.

In both of the incidents described above PSW Student #S124 and RPN #S120 did not report information known to them related to the abuse of a resident, immediately to the Administrator, DOC or designate. PSW Student #124 reported information known of a witnessed abuse two days after the incident. In the case of the second incident, it was the affected resident who brought forward information. In an interview with RPN #S120, she indicated that she started vacation on the following day of the incident and did not have an intention to report the information known related to the verbal abuse of Resident #55, due to fear of repercussion from other staff.

Related to s.97 of the Regulations, WN #17 of this Inspection Report:

The licensee did not ensure that the resident and the resident's substitute decision maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon the completion of the investigation.

In accordance with section 23 of the Act, every licensee shall ensure that every alleged suspected or witnessed incident of abuse of a resident by anyone, is immediately investigated.

As it relates to the incident involving: PSW #S126, PSW Student #S124 and Resident #53: On May 25, 2015, Inspector #148 contacted the substituted decision maker (SDM) for Resident #53, as this resident does not make his/her own decisions. The resident's SDM indicated that they were made aware of the incident and that the home would investigate, however, had not yet been made aware of the results of the home's investigation to date.

As it relates to the incident involving, PSW #S123, RPN #S120 and Resident #55: On May 26, 2015, Inspector #148 spoke with Resident #55, who makes his/her own care decisions. The resident reported that he/she was aware that the police were investigating the issue but that he/she was not aware that the home had conducted an investigation nor aware of the results of any such investigation.

Related to section 20(2) of the Act, WN #13 of this Inspection Report:

The licensee did not ensure that, at a minimum, the written policy to promote zero tolerance of abuse and neglect of residents, shall (d) contain an explanation of the duty under section 24 to make mandatory reports.

Inspector #148 reviewed the policies identified above. The policies describe the homes internal process of immediately reporting incidents to the Ministry of Health and Long Term Care including the Mandatory Critical Incident System, Centralized Intake, Assessment and Triage Team and use of the after-hours pager system.

As per policy AM #6.9, “Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Home’s Administrator or appropriate designate,” and “Every incidence of alleged, suspected or witnessed neglect or abuse shall be immediately reported to OMNI Home Office and the Ministry of Health and Long Term Care by the home upon learning of such an incident.” Policy AM #6.7 indicates that the home shall contact the Ministry of Health immediately upon becoming aware of abuse or neglect of a resident.

The policy to promote zero tolerance of abuse and neglect of residents does not include an explanation of the duty under section 24, for any person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report that suspicion and the information upon which it is based to the Director, as defined by section 2 (1) of the Act.

Related to s.96 of the Regulations, WN #16 of this Inspection Report:

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate and (e) identifies the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

Inspector #148 reviewed the policies identified above. Policy #AM-6.9 indicates that abuse will not be tolerated in the home by staff, volunteers or any other person in the home, that the home will hold any individual who has committed abuse against a resident accountable for their actions, that any employee who neglects or abuses a resident shall be subject to disciplinary action up to and including termination of employment and/or reporting of a health professional to his or her regulatory college or association, that any employee alleged to have committed an abusive or neglectful act shall immediately be removed from the work environment pending investigation.

The home's policy to promote zero tolerance of abuse, contains procedures and interventions to deal with staff who abuses or neglects a resident or how is alleged to have abused or neglected a resident. The policies identified above do not contain procedures and interventions to deal with "persons", as appropriate, who have abused or neglected or allegedly abused or neglected residents.

In addition, policy #AM-6.9 includes a description of training to be provided to staff including the home's Respect Always program, identification of abuse and neglect and situations that may lead to abuse and neglect and avoidance of such situations and that this training will be provided on orientation and annually thereafter. The policies reviewed do not identify training on the relationship between power imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 9. (1) 2., whereby the

licensee did not ensure that all doors leading to non-residential areas that are equipped with locks are kept closed and locked when they are not being supervised by staff.

On October 30, 2014 Inspection Report #2014_198117_0026 was issued to the home related to the Resident Quality Inspection of October 2014. Within this report, Inspector #148 and Inspector #573 identified a set of double doors which led to a non-residential area; the doors were not equipped with a lock. This non-compliance was issued with additional action including a voluntary plan of correction (VPC).

On May 19, 2015, during the initial tour of the home, Inspector #550 observed a set of double doors, unlocked with no staff supervising the non-residential area. Upon further inspection, Inspector #148 confirmed the doors to be the same double doors as identified in the October 2014 inspection report.

The double doors are located centrally in the home between the South and North units and are accessible to residents. It was confirmed that the doors are not equipped with a lock and there is a sign on the door indicating that the doors are to be kept closed at all times. Beyond the double doors is a long corridor within which are several utility type rooms, such as laundry, kitchen, staff room, storage and maintenance. Each of these rooms were equipped with a door and found to be closed and locked when unsupervised.

In addition, at the end of the corridor is a door leading to the outside which is equipped with a lock and audible alarm system; this door was observed to be propped open with bypass engaged for the purposes of receiving supplies; the door is also used as an entrance/exit for staff. The corridor itself is used as a storage area whereby boxes, linen carts, laundry bins, buckets and other miscellaneous items are found from time to time. There are postings within the corridor including staff information related to health and safety, employment opportunities and infection control.

At no time during observations of this area, were residents observed to be in the area beyond the double doors, nor is there a space in which residents may congregate or would otherwise need to access.

Inspector #148 discussed the non-compliance of October 2014 and the current status of the double doors and area beyond the doors, with the home’s Administrator. The home’s Administrator indicated that upon discussion with representatives of the licensee, it was determined that the double doors did not require a lock as each door

within the corridor, i.e the doors leading to the mechanical room, staff room or laundry, were kept closed and locked when not supervised. Upon further discussion, the home's Administrator described the area beyond the double doors to be a residential area, indicating that on occasion a resident may access the corridor to drop off clothes to be labelled or to seek out a maintenance staff member. Inspector #148 spoke to maintenance staff #S110 and Laundry aid #S138, both of whom are regularly in this corridor, and who reported that residents do not use the corridor.

The double doors, as described above, lead to a non-residential area whereby the double doors are to be equipped with a lock and kept closed and locked when not supervised.

Further exasperating the risk to residents is the door, located at the end of this corridor, that leads to the outside that was found to be unlocked on two separate occasions. During the initial tour of the home by Inspector #550 on May 19, 2015 and an additional observation by Inspector #545 on May 20, 2015, the door leading to the outside of the home, located at the end of the corridor described above, was found to be unlocked.

The home's Administrator was made aware of these observations on May 20, 2015. On the morning of May 21, 2015, Inspector #148 was approached by the Administrator to review the door leading to the outside, as he was unable to identify any issues with the locking mechanism. In the presence of the Administrator and Maintenance staff #S110, it was found that at times when the door is not pulled closed, the magnets located at the top of the door do not touch. When this occurs the distance between the magnets is sufficient to produce the current required to engage the magnetic lock system, whereby the door is closed, appears to be locked and the alarm is engaged. However, given that the magnets are centimeters apart the door is not in fact locked. When in this position, the door can be pushed open, at which time the alarm sounds. This was consistent with the observations made by Inspectors on May 20 and 21, 2015. Inspector #148 confirmed with the Administrator and Staff #S110 that adjustments were made to the magnets to ensure the door is secure. [s. 9. (1) 2.]

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations 2007, c. 8, s. 8 (3). (Log # O-001154-14)

A complaint was submitted to the Ministry of Health and Long Term Care regarding a lack of nursing staff.

Woodland Villa is a 111 bed Long-Term Care Home in Long Sault.

The Registered nursing staffing schedule from March 13 to May 27, 2015 was reviewed. As per the reviewed schedules, there was no Registered Nurse on duty and present in the home for the following 13 shifts:
March 17, 20, 30, 2015, there was no RN present on the night shift.
April 1, 6, 7, 8, 9, 12, 17, 23 and 28, 2015, there was no RN present on the night shift.
April 26, 2015, there was no RN present on the evening shift.

On May 28, 2015, the DOC confirmed to Inspector #592 that on the above dates, there was no RN on duty and present in the home. The DOC stated that there were Registered Practical Nurses present on site and a Registered Nurse available by telephone when the home was not able to fill the RN shifts. When the staffing plan was reviewed with the DOC, it was reported that the home will attempt to contact all available RNs, on staff, to fill a vacant shift. If the home is unsuccessful an RPN will be contacted to replace the RN shift. She further added that the home did struggled a few weeks ago filling the Registered Nurse night position due to an unexpected temporary leave of two staff members. She further indicated that the home has recruited four RN's to ensure that Registered Nurse shifts are covered.

Under O.Reg. 79/10, s. 45. (2) an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home. In an interview with the DOC it was confirmed that on the dates identified above, there was no unforeseen situation of a serious nature that prevented a Registered Nurse who was schedule from getting to the long-term care home.

The licensee did not ensure that there was a registered nurse on site at all times, in the long-term care home. [s. 8. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident-staff communication and response system calls be cancelled only at the point of activation.

The resident-staff communication system uses sound to alert staff, as per O. reg. 79/10, s. 17(1)(g). When a call is made, the sound can be silenced by pressing the "signal" button on the system console at the nurse station, which effectively serves to cancel the call. Staff do not have to go to the point of activation to silence the system. It is noted that a dome light remains illuminated outside of the resident bedroom or other location from which a call has been made until such time as staff deactivate the system from that point of activation.

During an interview, the Director of care indicated to Inspector #550 calls can be cancelled by staff by pressing the "signal" button on the console at the nursing station. [s. 17. (1) (c)]

2. The licensee did not ensure that the resident-staff communication and response system available in every area accessible by residents.

At the beginning of each wing there is a sitting lounge area furnished with sitting chairs for residents and visitors; one for the Aultsville and Moulinette wing and one for the Wales and Farrans wing. There is also a sitting area in the Administration hallway in front of the south nursing station that is equipped with a wall mounted television and chairs placed along the walls where residents gather to watch television. Inspector #550 observed these resident accessible areas are not equipped with a resident-staff communication and response system.

Throughout the course of the inspection from May 20 to 28, 2015, Inspectors #550, #545, #592, #148 observed various residents sitting in these sitting areas at various times during the day.

During an interview, the Director of Care indicated to Inspector #550 the two sitting areas at the beginning of each wings and the sitting area in the administration hallway are not equipped with a resident-staff communication and response system. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system is available in every area accessible by residents and allows calls to be cancelled only at the point of activation, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident’s plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee did not ensure that the restraining of a resident by a physical device was included in the plan of care.

On the afternoon of May 20 and May 26, 2015, Inspector #545 observed Resident #17 reclined in a tilt wheelchair, with a padded table top in place, alone in the resident's bedroom. On May 26, 2015 the resident was observed by the Inspector, in the presence of PSW #S129, with both arms placed under the table top, skin of the right elbow was squeezed between the table top and the arm rest of the wheelchair. When the resident pulled his/her arm out, a red area of approximately 4 inches in diameter was observed. The PSW put the tilt wheelchair in an upright position allowing the resident to be in a sitting position, the Inspector then asked the resident if he/she could remove the padded table top. With several attempts, the resident was physically unable to remove it.

The resident's health record was reviewed. A progress note indicated that the resident had recently received a new wheelchair. A physician order, consent from the substitute decision maker (SDM), documented assessment and monitoring of the physical restraints were not found. The most recent plan of care, indicated that

Resident #17 the recently acquired chair with tilt ability, there was no information regarding the use of physical restraints in the resident's plan of care.

During an interview with PSW #S129 on May 26, 2015, she indicated that she was not aware that the resident was unable to remove the table top, adding that if the resident was unable to remove, it was considered a physical restraint and hourly monitoring was required. In reviewing the Restraint Book, PSW #S129 indicated that staff were not doing hourly monitoring of the tilt wheelchair or the padded table top. The PSW indicated that the resident received this new wheelchair recently and that the table top came with it, but was not sure why it was being used.

During an interview with RN #S130 on May 26, 2015, she indicated that if the resident was unable to rise from the tilt wheelchair and unable to remove the table top, then these devices would be considered physical restraints and an order, a consent from the SDM, assessment & reassessments and hourly monitoring would be documented. The RN checked the resident's chart and was unable to locate documentation, adding that she was not sure why the resident required a table top.

During an interview with the DOC on May 27, 2015 she indicated she was responsible to conduct Personal Assistive Device and Restraint Audits, adding that at the time of the last audit in April 2015, Resident #17's physical restraints were not on the list for assessment. She indicated that the resident's tilt wheelchair and accessories were recently acquired and that an assessment should have been completed at that time and only if the restraints were required, an order from the physician would have been requested, a consent from the SDM and hourly monitoring would have been initiated, including reassessment by registered staff. She further indicated that the restraining by a physical device including the tilt wheelchair and the padded table for Resident #17 were not included the plan of care. [s. 31. (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 the restraining of a resident by a physical device is included in the plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

During health care record reviews and staff interviews of a randomly selected sample of 40 resident's a trend was noted by the inspection team whereby monthly weights were not available for each resident.

Inspector #148 reviewed the resident weight records as available within each tub/shower room and electronic documentation of body weights available within Med e-care.

As of May 22, 2015, seventeen residents were identified whereby monthly body weights were not completed for the month of April and preceding months. This is exampled by the following residents without monthly weights completed:
Resident #17 for the month of January and April 2015
Resident #22 for the month of March and April 2015
Resident #23 for the month of February and April 2015
Resident #50 for the month of February, March and April 2015
Resident #51 for the month of January and April 2015
Resident #52 for the month of January, February and April 2015

In addition to the six residents identified above, fifteen more residents, for a total of 21 residents, did not have a weight completed for the month of May 2015 as of May 22, 2015. Staff indicated that the home's practice is to complete weights within the first week of the month during bath days.

Residents who were identified without monthly weights were reviewed with PSW staff and Registered staff. It was reported that on the North side unit, there is a broken chair lift impacting on the staffs ability to perform weight measures on each resident. The chair lift has been in disrepair, for potentially more than 1 month, although a quote for repair has been obtained, the equipment remains in disrepair.

In an interview, the home's Registered Dietitian indicated an awareness of the incomplete weights and that as a result weights have not always been accessible for the purposes of nutritional assessment. [s. 68. (2) (e) (i)]

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 weight monitoring system measures and records weight monthly for each resident, to be implemented voluntarily.

WN #7: 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).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. (Log #O-001006-14)

The Medication Administration Records Sheets (MARS) were reviewed over a 7 week period in 2014 that covered two separate months, for Resident #41. The records indicate that the order for a diuretic was revised during this time period. Nine instances were identified in which the revised order for the diuretic was not administered in accordance with the physician's order. In addition, an antibiotic was ordered during this time frame. Three instances were identified in which the antibiotic was not administered in accordance with the physician's order.

The DOC indicated that if a resident is refusing a medication, the expectation would

be that the registered nursing staff administering the medication, record the refusal on the MARS and indicate the refusal in the progress notes. No such refusals were documented for the instances noted above.

On May 22, 2015, during an interview with the DOC, she indicated that during the time period reviewed by the Inspector, the home had hard copy MARS. The home's process was to have every new order prescribed by the physician reviewed and co-signed by two registered nursing staff members. Once the order has been reviewed it is then processed to the pharmacy and changes would be made accordingly on the MARS by the registered nursing staff.

Upon showing the physician orders to the DOC and the MARS for the time period reviewed, she confirmed that drugs were not administered to Resident #41 in accordance with the directions for use specified by the prescriber. She further added that it appeared the two registered nursing staff members who completed the review of the new orders did not make the appropriate changes on the MARS to reflect the current administration of diuretic for the coming month. [s. 131. (2)]

2. The licensee did not ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On May 20, 2015, during a resident interview, Inspector #550 observed Resident #40 to have a two types of inhalers, eye drops and a cardiac medication on a small table near the window in his/her bedroom. Resident #40 indicated to the Inspector that he/she keeps these medications in the bedroom and self administers both inhalers, eye drops and cardiac medication.

Inspector reviewed Resident #40's health care record and observed there to be no physician order indicating the resident may self administer the inhalers, eye drops or the cardiac medication.

The Director of Care indicated to the Inspector that all residents who self administers medication(s) needs to have a physician order to do so and need to have an assessment done to ensure their capacity to self administer. Both would be documented and a record is kept in the resident's health record. She further indicated that Resident #40 does not have a physician's order to self administer the medication identified. [s. 131. (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 drugs prescribed for residents are given in accordance with the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee did not ensure that each resident admitted to the home must be screened for tuberculosis (TB) within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

The home's DOC provided the completed Infection Prevention and Control checklist as required. Upon discussion with the home's DOC, she indicated that the home conducts 2-Step Mantoux testing to screen newly admitted residents. The fridge used to store the tuberculin used for the Mantoux test has been in disrepair, time was estimate to be weeks. In addition, the home had a recent power outage on the weekend and the public health unit will not supply the tuberculin required until there are adequate refrigeration temperatures for a consecutive two weeks. The home has not been able to provide two weeks of temperatures and therefore have not been able to obtain a re-supply of tuberculin.

On May 27, 2015, Inspector #148 reviewed the health care records of three residents, Resident #60, #61 and #62, all newly admitted to the home. Resident #61 and Resident #62 did not have any indication of TB screening within 14 days of admission nor any documented results of screening within the last 90 days. Resident #60 was provided with step 1 of the 2-Step Mantoux, according to the nursing report book, which produced a negative result. The second step of the 2-Step Mantoux was scheduled, however, was not completed. Upon further discussion with the home's DOC, she suspects that the tuberculin was unavailable for the second step, due to the storage issues identified above. [s. 229. (10) 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 each resident admitted to the home is screed for TB within 14 days of admission, in addition the home will ensure TB screening of Residents #60, #61 and #62, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 :

The licensee did not 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.

Resident #24 has a history of cancer and requires extensive assistance with all activities of daily living and moderate cognitive impairment.

On May 21 and 22, 2015, the Inspector observed a small lesion on the resident's face. The area was scabbed over with a small amount of dried blood on one side. The resident was picking at the scab during the observation.

During an interview with PSW #S105 on May 22, 2015, she indicated that different types of topical creams have been prescribed over the years but the lesion has never healed. PSW #S105 indicated that presently no topical creams were prescribed but that she has been applying a zinc based topical cream as she feels it is helpful, adding that she had applied some this morning. She indicated that the resident tends to pick at the scab and when it falls off, the area is raw.

During an interview with the Wound Care Nurse #S103 on May 22, 2015, she

indicated that the lesion for Resident #24 has been long standing, adding that the resident always picks at it. Staff #S103 indicated that a topical cream with antibacterial properties, was ordered for the resident, but has since been discontinued. Staff #S103, indicated that at this time no treatment was prescribed and that the area was left open. The Wound Care Nurse indicated she was not aware that PSW #S105 applied a zinc based cream to the area, adding that it was probably a good idea as it kept the area moist and might prevent it from crusting and hurting the resident.

Upon review of the resident's most recent RAI-MDS 2.0 assessment (April 21, 2015), no lesions or treatment were identified under the Skin Condition section of the assessment.

Upon review of the resident's plan of care with the Wound Care Nurse #S103, she indicated that there was no written plan of care for Resident #24 that set out the planned care for the skin lesion; goals the care was intended to achieve; and clear directions to staff and others who provide direct care to Resident #24. [s. 6. (1)]

2. The licensee did not ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

Over the course of the inspection, both Resident #42 and #32, were observed to not wear glasses.

The plans of care for both residents, as it relates to vision care, indicated that glasses are to be cleaned and worn, or offered to the resident for use daily.

Several staff including PSWs and Registered Nurses, who are familiar with the resident's care, were interviewed. Staff could not recall Resident #42 having ever worn or possessed glasses. Staff indicated that Resident #32 no longer wears eye glasses and has not worn them for a very long time indicating that the resident no longer has glasses in the home.

RN #S100 indicated to Inspector #550 that it is the responsibility of the RN or RPN to update a resident's plan of care whenever there is a change to ensure that the written plan of care reflects the planned care for the resident. In the case of Resident #42 and #32, the plan of care did not reflect the planned care related to vision.
(550 and 592) [s. 6. (1)]

3. The licensee did not ensure that the care set out in the plan of care is based the

assessment of the resident and the needs and preferences of that resident.

Inspector reviewed the health care record of Resident #40, which demonstrated four fall incidents over one month. Post fall assessments were completed for two of the four falls and a fall risk assessment was completed recently by the home's Physiotherapist (PT) which determined the resident to be at high risk for falls. The home's DOC reported that the resident's falls were discussed at the morning manager meeting and as a result, the night staff are more involved in assisting the resident with night care.

A review of the most recent plan of care, did not make any reference to the resident's risk for falls or any interventions in place to mitigate or prevent the risk of falls. (550) [s. 6. (2)]

4. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #24 was assessed at high risk for falls and had an unwitnessed fall in early May 2015, with no injuries.

During an interview with PSW #S112 on May 25, 2015, she indicated that she transferred Resident #24 from bed to commode and from bed to wheelchair and vice-versa by herself. She indicated that the resident was light and because the resident could weight bear she didn't need the assistance of a second person to transfer the resident. When asked how the plan of care directed staff on transferring the Resident, she indicated she didn't know because she didn't look at the plan of care. When asked what the Transfer Code above the resident's bed identified for transfer needs, she indicated she didn't know as she had not looked at it.

A progress note dated in early 2015, written by the Physiotherapist, indicates that Resident #24 requires assistance of two persons for transfer, due to mild lower weakness and poor balance. Further to this the note indicates that the resident was non ambulatory and was dependent on a tilt wheelchair for mobility.

The most recent plan of care indicated that Resident #24 was a two-person physical assist for all transfers, including for toileting on the commode.

The transfer code sign above the resident's bed indicated that the Resident was a 2-person pivot transfer.

During an interview with the physio-assistant #S113, he indicated that the resident was a two-person transfer and that all staff needed to provide care as per the plan of care, including the Transfer Code above the resident's bed. He indicated that staff could use a higher level of transfer technique if the resident required it, but staff could not use a lower level transfer technique such as a one-person transfer. [s. 6. (7)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee did not ensure that the home, furnishings and equipment are kept clean and sanitary.

On May 20, 2015, the Inspector observed the following equipment unclean:
- a large amount of white stains covering both footrests of Resident #17's wheelchair

- a pink sticky debris stuck to the right footrest of Resident #24's wheelchair, dust, debris and hairs covering the frame of the wheelchair, and white stains on the cushion of the wheelchair

The North End and South End May schedules were reviewed by the Inspector. Resident #17 and #24's wheelchairs were scheduled to be cleaned the night shift of May 20, 2015. Staff initials were documented for both wheelchairs for May 20, 2014.

On May 28, 2014, the wheelchairs for both Resident #17 and #24 were observed to be in the same state of uncleanliness as was observed on May 20, 2015.

On May 28, 2015, during an interview with the Housekeeping Aide #S134, she indicated that the Housekeeping Staff were not responsible for the cleaning of the mobility aides; adding that the company "Shoppers" comes in at specific times to clean the mobility aids.

On May 28, 2015, during an interview with PSW #S136, she indicated that the night staff were responsible to clean wheelchairs as per a set schedule. She indicated that when she worked the night shift, she removed the assigned wheelchairs from the resident's rooms, placed them in the hallways and wiped them down using a disinfectant.

During an interview with the DOC on May 28, 2015, she indicated that night staff were responsible for cleaning the wheelchairs as per the North and South End schedules placed at each nursing stations. Accompanied by the Inspector, the DOC observed the wheelchairs of Resident #17 and #24 and confirmed that all equipment observed were unclean and not sanitary. [s. 15. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On May 20, 2015, at 11:30am, the Inspector observed a window in a resident's bedroom fully opened at 83cm. The resident residing in the room indicated to the Inspector that the window will soon be locked in place once the maintenance staff installs the air condition unit, further adding that at other times of the year, the window can be opened to the fullest.

On May 28, 2015, at 8:40am, the Inspector observed the window in the same resident bedroom, to be fully opened, at 83cm.

During an interview with the Maintenance Staff #S110 on May 28, 2015, he indicated that the home's expectation was to install a stopper on all windows in the home to ensure the windows could not be opened more than 6 inches (15cm). He indicated that the window identified by the Inspector was an exception because the resident liked to open the window at its full capacity to enjoy fresh air, adding that a note might be on the resident's chart regarding this preference, as when the resident moved into the room last summer the resident and family approached #S110 to request that the stopper on the window be removed to allow the window to be fully opened. Staff #S110 indicated the window has had no stoppers since shortly after the resident moved to the identified bedroom, further indicating that an air condition unit would be installed today, thus preventing the window from opening for the remainder of the summer.

During an interview with the Administrator on May 28, 2015 he indicated that it was the expectation of the home to ensure that every window in the home that opens to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimeters. He indicated that he was not aware that the window identified by the Inspector had no stopper, allowing it to be fully opened, adding that steps would be taken to ensure the window would no longer open more than 15cm. [s. 16.]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (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).

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

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with.
(Log O-001474-15, O-001457-14 and O-002009-15)

As identified, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse

Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

The policy includes the following: failure of an employee to report a suspected or witness incident of neglect or abuse shall be subject to disciplinary action; any person who has reasonable grounds to suspect abuse is obligated to report the information to the Home's Administrator or designate; a staff member who witnesses, suspects or hears about an act of abuse or neglect, shall report the incident to a direct manager, DOC or Administrator.

On a specified date, PSW #S126 was witnessed by PSW Student #S124 to use profanities and call Resident #53, disgusting during the provision of toileting care. No injury was sustained and the resident does not recall the events. On a morning two days after the incident, PSW Student #S124 reported the information to her preceptor at which time the home’s management were made aware. The home began an investigation on the same date, which was concluded approximately 2 weeks later resulting in the termination of employment for PSW #S126.

On a specified date, PSW #S123 was witnessed by RPN #S120, to raise her voice and speak inappropriately to Resident #55. The resident reported that PSW #S123 had slapped him/her across the face and pulled at the resident’s arm during assistance with a transfer, both causing the resident pain. The resident further reported that PSW #S123, had spoken to the resident inappropriately including telling him/her to shut up and that he/she was stupid. On the following morning, the resident reported the incident to PSW #S125 during care, in which PSW #S125 shared the information with the home's management. The home’s DOC reported that the home began an investigation on the same day, which concluded one day later, resulting in the termination of employment for PSW #S123.

The home’s DOC confirmed that all staff identified above were provided with orientation or annual training on the home’s policy to promote zero tolerance of abuse and neglect of residents, as appropriate.

In both of the incidents described above PSW Student #S124 and RPN #S120 did not report information known to them related to the abuse of a resident, immediately to the Administrator, DOC or designate. PSW Student #124 reported information known of a witnessed abuse two days after the incident. In the case of the second incident, it was the affected resident who brought forward information. In an interview with RPN #S120, she indicated that she started vacation on the following day of the incident and did not have an intention to report the information known related to the verbal abuse of

Resident #55, due to fear of repercussion from other staff.

2. The licensee did not ensure that, at a minimum, the written policy to promote zero tolerance of abuse and neglect of residents, shall (d) contain an explanation of the duty under section 24 to make mandatory reports.
(Log O-001474-15, O-001457-14 and O-002009-15)

As identified, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

Inspector #148 reviewed the policies identified above. The policies describe the homes internal process of immediately reporting incidents to the Ministry of Health and Long Term Care including the Mandatory Critical Incident System, Centralized Intake, Assessment and Triage Team and use of the after-hours pager system.

As per policy AM #6.9, "Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Home's Administrator or appropriate designate," and "Every incidence of alleged, suspected or witnessed neglect or abuse shall be immediately reported to OMNI Home Office and the Ministry of Health and Long Term Care by the home upon learning of such an incident." Policy AM #6.7 indicates that the home shall contact the Ministry of Health immediately upon becoming aware of abuse or neglect of a resident.

The policy to promote zero tolerance of abuse and neglect of residents does not include an explanation of the duty under section 24, for any person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report that suspicion and the information upon which it is based to the Director, as defined by section 2 (1) of the Act. [s. 20. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

During a staff interview, RN staff #S100 indicated to Inspector #550, that Resident #40 had recently sustained a fall. Upon a review of Resident #40's health record, it was determined that Resident #40 had sustained four falls in fourteen days. Fall #1, #2, #3 and #4 occurred in the resident's bedroom with no injuries reported.

A post-fall assessment was completed and documented in Resident #40's health record after fall #1 and #2. No post-fall assessment was completed after the fall #3 and #4.[s. 49. (2)]

2. Related to Log #O-001006-14

On a specified date, Resident #41 was found on the floor by a registered nursing staff member. At the time of the incident the resident was complaining of pain;later the same day the resident required further assessment in hospital.

Upon a review of the health care record, Inspector #592 was unable to find a post fall assessment for Resident #41.

On May 22, 2015, during an interview with RPN #S101, she indicated to the Inspector that when a resident has fallen, the Registered nursing staff are responsible to complete a post fall assessment tool which should be completed immediately after the fall.

During interviews with the DOC, it was reported that a post fall assessment is to be completed by the registered staff each time a resident has a fall. The DOC explained that the post fall assessments are forwarded to her to inform her of the fall incidents and to ensure follow up is completed. On request, the DOC was unable to locate the post fall assessments, as indicated above, for both Resident's #40 and #41. [s. 49. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate and (e) identifies the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.
(Log O-001474-15, O-001457-14 and O-002009-15)

As identified by the home’s DOC, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee’s policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

Inspector #148 reviewed the policies identified above. Policy #AM-6.9 indicates that abuse will not be tolerated in the home by staff, volunteers or any other person in the home, that the home will hold any individual who has committed abuse against a resident accountable for their actions, that any employee who neglects or abuses a resident shall be subject to disciplinary action up to and including termination of employment and/or reporting of a health professional to his or her regulatory college or association, that any employee alleged to have committed an abusive or neglectful act shall immediately be removed from the work environment pending investigation.

The home’s policy to promote zero tolerance of abuse, contains procedures and interventions to deal with staff who abuses or neglects a resident or how is alleged to have abused or neglected a resident. The policies identified above do not contain procedures and interventions to deal with “persons”, as appropriate, who have abused or neglected or allegedly abused or neglected residents.

In addition, policy #AM-6.9 includes a description of training to be provided to staff including the home’s Respect Always program, identification of abuse and neglect and situations that may lead to abuse and neglect and avoidance of such situations and that this training will be provided on orientation and annually thereafter. The policies reviewed do not identify training on the relationship between power imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. [s. 96.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident’s substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident and the resident’s substitute decision maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon the completion of the investigation.
(Log O-001474-15, O-001457-14 and O-002009-15)

In accordance with section 23 of the Act, every licensee shall ensure that every alleged suspected or witnessed incident of abuse of a resident by anyone, is immediately investigated.

On a specified date, PSW #S126 was witnessed by PSW Student #S124 to use profanities and call Resident #53, disgusting during the provision of toileting care. The home began an investigation two days after the incident, which was concluded approximately 2 weeks later resulting in the termination of employment for PSW #S126.

On May 25, 2015, Inspector #148 contacted the substituted decision maker (SDM) for Resident #53, as this resident does not make his/her own decisions. The resident’s SDM indicated that they were made aware of the incident and that the home would investigated, however, had not yet been made aware of the results of the home’s investigation to date.

On a specified date, PSW #S123 was witnessed by RPN #S120, to raise her voice and speak inappropriately to Resident #55. The resident reported that PSW #S123 had slapped him/her across the face and pulled at the resident’s arm during assistance with a transfer, both causing the resident pain. The resident further reported that PSW #S123, had spoken to the resident inappropriately including telling him/her to shut up and that he/she was stupid. On the following morning, the home began an investigation, which concluded one day later, resulting in the termination of employment for PSW #S123.

On May 26, 2015, Inspector #148 spoke with Resident #55, who makes his/her own care decisions. The resident reported that he/she was aware that the police were investigating the issue but was not aware that the home had conducted an investigation nor aware of any of the results of any such investigation. [s. 97. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

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 did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home must be investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

During an interview with Resident #16, it was reported that he/she recently lost a personal item of value, indicating that it was stolen and the resident believed that an employee had taken it. The resident also indicated that he/she kept the bedroom door closed at all times and his/her closet locked, as the resident worried about wandering residents coming into the bedroom.

A review of the home's Complaints Log revealed no complaints for the year 2015. In June and September 2014, two complaints were received regarding concerns of residents wandering in other residents' room, one mentioning rummaging.

The Complaints Procedure, Policy # AM - 6.1 dated November 2010 was provided by the Administrator and reviewed by the Inspector. Under the section Policy on page 1 of 4, item 1 indicated that "Every complaint made related to the care of a resident or the operation of the home shall be investigated in a timely, thorough and impartial manner". Under the section Procedure on page 2 of 4, item 1 indicated that "Any complaint given to a staff member, whether verbal or written, shall be directed or communicated immediately to the Administrator of the home.

Interviews with staff members #S110, #S134, #S119, #S132 and #S135, indicated they were not aware of Resident #16's lost personal item. Staff member #S110 indicated that if a complaint was reported to him, he would notify his manager, staff member #S135 and #S132 indicated they would document a note in the 24-hour report and/or 24-hour checklist then a note would be documented in the resident's health record. None of the staff interviewed indicated they would notify the Administrator or were aware of other process as per the home's policy.

A review of Resident #16's health record was conducted. Two notes were found, both relating to the missing personal item and staff attempts to locate the item without success.

The 24-hour checklist used by nursing staff, also contained a note indicating the resident was upset about the missing personal item.

During an interview with the Administrator on May 28, 2015, he indicated that staff were responsible to notify him of any verbal or written complaints, further adding that at the daily Management Team Meeting a review of the 24-hour report was done and that complaints were discussed at that time. He indicated that he was unable to locate any documented record of complaints made in 2015 and that he had not been made aware of the missing personal item belonging to Resident #16. The Administrator indicated that he would initiate an investigation of the missing personal item immediately. [s. 101. (1) 1.]

2. The licensee did not ensure that a documented record was kept in the home that included the nature of the written complaints, the type of action taken to resolve the

complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

Upon request of the home's Complaints Log on May 27, 2015, the DOC provided two binders to the Inspector: a Complaints Log and the Residents' Council Minutes for 2014 which included meeting minutes and residents' complaints. The DOC indicated that no documented records for 2015 were found.

During an interview with the Administrator on May 28, 2015, he indicated that he was unable to locate any documented record for complaints lodged in 2015, added that the complaint reported by Resident #16 regarding a missing personal item, which was documented by a registered nurse in the resident's health care record and in the 24-hour report, was not documented within the complaints log, as per legislation. [s. 101. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

O. Reg. 79/10, s. 104 (1).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,

iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee did not ensure that in making a report to the Director under subsection 23(2) of the Act, that the report with respect to an alleged, suspected or witnessed incident of abuse of a resident includes, 2.ii., names of any staff members or other persons who were present at or discovered the incident and 3.v., the outcome or current status of the individual or individuals who were involved in the incident.
(Log O-001474-15, O-001457-14 and O-002009-15).

On a specified date, PSW #S126 was witnessed by PSW Student #S124 to use profanities and call Resident #53, disgusting during the provision of toileting care. No injury was sustained and the resident does not recall the events. On a morning two days after the incident, PSW Student #S124 reported the information to her preceptor at which time the home’s management were made aware. The home began an investigation on the same date, which was concluded approximately 2 weeks later resulting in the termination of employment for PSW #S126.

The home’s interim DOC submitted a Critical Incident Report (CIR) to the Director on December 19, 2015, no amendments were submitted. The CIR did not include the outcome of the individual involved.

On a specified date, PSW #S126 was witnessed by PSW Student #S124 to use profanities and call Resident #53, disgusting during the provision of toileting care. No injury was sustained and the resident does not recall the events. On a morning two days after the incident, PSW Student #S124 reported the information to her preceptor at which time the home’s management were made aware. The home began an investigation on the same date, which was concluded approximately 2 weeks later resulting in the termination of employment for PSW #S126.

The home’s DOC submitted a Critical Incident Report (CIR) to the Director on April 22, 2015, an amendment was submitted on April 25, 2015. The CIR did not include the names of all individuals involved including PSW #S123 and RPN #S120. [s. 104. (1)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that that drugs are stored in an area or a medication cart, ii. that is secure and locked.

On May 20, 2015, Inspector #550 observed a jar of topical cream on a shelf in Resident #37's bathroom and a tube of anti-inflammatory topical cream on the night table in the resident's bedroom. PSW staff #S131 indicated to Inspector #550, that staff keep the creams for Resident #37 in the bathroom as they have to apply it often.

On May 20, 2015, Inspector #545 observed a jar of anti-fungal topical cream on the counter in Resident #14's bathroom. During an interview, Resident #14 indicated to Inspector #550, that he/she always keeps the cream in the bathroom as PSW's apply it twice daily.

The DOC indicated to Inspector #550, that all drugs have to be stored in a locked area or locked medication cart at all times. [s. 129. (1) (a)]

Issued on this 29 day of July 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148) - (A1)
Inspection No. / No de l'inspection :	2015_200148_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	O-001968-15 (A1)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 29, 2015;(A1)
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	WOODLAND VILLA 30 Milles Roches Road, R. R. #1, Long Sault, ON, K0C-1P0

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

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 : MICHAEL RASENBERG

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_200148_0041, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all allegations of resident abuse and neglect are
reported and investigated in accordance with the legislated requirements.

The licensee shall submit a written plan that, at minimum, includes:
- A revision of the policy to promote zero tolerance of abuse and neglect of residents to include an explanation of the duty under section 24 to make mandatory reports;
- Education of all staff related to the revised policy to promote zero tolerance of abuse and neglect of residents;
- A process to audit each investigation into allegations of resident abuse and neglect to ensure compliance with the legislation. Additionally, the home will develop a written plan of corrective action to address any failures identified.

The plan shall be submitted in writing to Inspector Amanda Nixon by fax #613-
569-9670, no later than June 18 , 2015.

Grounds / Motifs :

1. On January 5, 2015, Inspector #148 issued Compliance Order (CO) #001 under Inspection #2014_200148_0041. The inspection was conduced in November 2014 related to two incidents of witnessed staff to resident abuse.

The grounds of the CO included, but was not limited to, compliance issues related to sections 20(1) and 20(2) of the Act and section 97 of the Regulations. The CO instructed the home to ensure all allegations of resident abuse and neglect are reported and investigated in accordance with the legislated requirements; to revise the policy to promote zero tolerance of abuse and neglect of residents to include an explanation of the duty under section 24 to make mandatory reports; to education of all staff related to the revised policy to promote zero tolerance of abuse and neglect of residents; and to develop a process to audit each investigation into allegations of resident abuse and neglect to ensure compliance with the legislation and to develop a written plan of corrective action to address any failures identified. The home was to have complied with the Compliance Order by March 9, 2015.

During this Resident Quality Inspection two Critical Incident Reports were reviewed related to alleged staff to resident abuse (one of which occurred prior to January 2015 and therefore will not be included in the grounds for this Order), in addition to the follow up of CO #001 issued January 2015. (Log O-001474-15, O-001457-14 and O-002009-15).

On May 29,2015, Inspector #148 discussed the CO of January 2015 and the most recent incident of alleged staff to resident abuse, with the home's Administrator. The Administrator reported that the licensee's policy to promote zero tolerance of abuse and neglect of residents had been updated in January 2015 and that all staff in the home had been provided with training on the updated policy. Inspector #148 was able to confirm the newly revised policy was dated January 2015 and that staff involved in the alleged staff to resident abuse reported had been provided with training on the abuse policy since January 2015. The Administrator reported that the home has implemented an audit tool, which he identified as the Mandatory Report Checklist. As it relates to the most recent incident of abuse, the Administrator noted that the checklist had been completed and no failures were identified.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of

physical force by anyone other than a resident that causes physical injury or pain.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Related to section 20(1) of the Act and WN #13 of this Inspection Report:

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

As identified, the policy titled Zero Tolerance of Abuse and Neglect of Residents, #AM-6.9, effective January 2015 is the licensee's policy to promote zero tolerance of abuse and neglect of residents, as required by section 20 of the Act. Policy #AM-6.9 references associated policies including: Whistleblowing Protection #AM-6.2, Investigation Procedures #AM-6.3, Reporting Incidents of Abuse #AM-6.7, Abuse Reporting Guidelines Table AM 6.7(a), and Disclosure of Critical Incident #AM-6.8.

The policy includes the following: failure of an employee to report a suspected or witness incident of neglect or abuse shall be subject to disciplinary action; any person who has reasonable grounds to suspect abuse is obligated to report the information to the Home's Administrator or designate; a staff member who witnesses, suspects or hears about an act of abuse or neglect, shall report the incident to a direct manager, DOC or Administrator.

On a specified date, PSW #S123 was witnessed by RPN #S120, to raise her voice and speak inappropriately to Resident #55. The resident reported that PSW #S123 had slapped him/her across the face and pulled at the resident's arm during assistance with a transfer, both causing the resident pain. The resident further reported that PSW #S123, had spoken to the resident inappropriately including telling him/her to shut up and that he/she was stupid. On the following morning, the resident reported the incident to PSW #S125 during care, in which PSW #S125 shared the information with the home's management. The home's DOC reported that the home began an investigation on the same day, which concluded one day later, resulting in the termination of employment for PSW #S123.

The home’s DOC confirmed that all staff identified above were provided with orientation or annual training on the home’s policy to promote zero tolerance of abuse and neglect of residents, as appropriate.

RPN #S120 did not report information known to her related to the verbal abuse of a resident, immediately to the Administrator, DOC or designate. Rather it was the affected resident who brought forward information on the morning after the incident to PSW #S125 who reported the information to the Administrator. In an interview with RPN #S120, she indicated that she started vacation the day after the incident and did not have an intention to report the information known related to verbal abuse, due to fear of repercussion from other staff.

Related to section 97(2) of the Regulations, WN #17 of this Inspection Report:

The licensee did not ensure that the resident and the resident’s substitute decision maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon the completion of the investigation.

In accordance with section 23 of the Act, every licensee shall ensure that every alleged suspected or witnessed incident of abuse of a resident by anyone, is immediately investigated.

As it relates to the incident involving, PSW #S123, RPN #S120 and Resident #55: : On May 26, 2015, Inspector #148 spoke with Resident #55, who makes his/her own care decisions. The resident reported that he/she was aware that the police were investigating the issue but that he/she was not aware that the home had conducted an investigation nor aware of the results of any such investigation.

Related to section 20(2) of the Act, WN #13 of this Inspection Report:

The licensee did not ensure that, at a minimum, the written policy to promote zero tolerance of abuse and neglect of residents, shall (d) contain an explanation of the duty under section 24 to make mandatory reports.

Inspector #148 reviewed the policies identified above, as the policy to promote zero tolerance of abuse and neglect of residents. The policies describe the homes internal

process of immediately reporting incidents to the Ministry of Health and Long Term Care including the Mandatory Critical Incident System, Centralized Intake, Assessment and Triage Team and use of the after-hours pager system.

As per policy AM #6.9, "Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Home's Administrator or appropriate designate," and "Every incidence of alleged, suspected or witnessed neglect or abuse shall be immediately reported to OMNI Home Office and the Ministry of Health and Long Term Care by the home upon learning of such an incident." Policy AM #6.7 indicates that the home shall contact the Ministry of Health immediately upon becoming aware of abuse or neglect of a resident.

The policy to promote zero tolerance of abuse and neglect of residents does not include an explanation of the duty under section 24, for any person with reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report that suspicion and the information upon which it is based to the Director, as defined by section 2 (1) of the Act.

Related to section 96 of the Regulations, WN #16 of this Inspection Report:

The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate and (e) identifies the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

Inspector #148 reviewed the policies identified above, as the policy to promote zero tolerance of abuse and neglect of residents. Policy #AM-6.9 indicates that abuse will not be tolerated in the home by staff, volunteers or any other person in the home, that the home will hold any individual who has committed abuse against a resident accountable for their actions, that any employee who neglects or abuses a resident shall be subject to disciplinary action up to and including termination of employment and/or reporting of a health professional to his or her regulatory college or association, that any employee alleged to have committed an abusive or neglectful act shall immediately be removed from the work environment pending investigation.

The home's policy to promote zero tolerance of abuse, contains procedures and interventions to deal with staff who abuses or neglects a resident or how is alleged to have abused or neglected a resident. The policies identified above do not contain procedures and interventions to deal with "persons", as appropriate, who have abused or neglected or allegedly abused or neglected residents.

In addition, policy #AM-6.9 includes a description of training to be provided to staff including the home's Respect Always program, identification of abuse and neglect and situations that may lead to abuse and neglect and avoidance of such situations and that this training will be provided on orientation and annually thereafter. The policies reviewed do not identify training on the relationship between power imbalances between staff and resident and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.

As indicated by the grounds, a compliance history exists with previous issuance of a Compliance Order, whereby the licensee did not ensure that the policy to promote zero tolerance of abuse includes all requirements of the Act including an explanation of section 24, nor has the licensee ensured that the policy has been complied with as it relates to the reporting of information immediately through the home's internal processes or that the residents and/or SDMs, as appropriate, are notified as required. In addition, the home was unable to identify these failures by use of the audit tool developed for that purpose. Further supporting the CO, is the lack of immediate reporting of information pertaining to a witnessed abuse, in particular, which poses a potential risk to residents.
(148)

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

Jul 31, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that the double doors leading to the service corridor, defined as a non-residential area, is equipped with locks to restrict unsupervised access to the area by residents, and that the doors are kept closed and locked when they are not being supervised by staff.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9. (1) 2., whereby the licensee did not ensure that all doors leading to non-residential areas that are equipped with locks are kept closed and locked when they are not being supervised by staff.

On October 30, 2014 Inspection Report #2014_198117_0026 was issued to the home related to the Resident Quality Inspection of October 2014. Within this report, Inspector #148 and Inspector #573 identified a set of double doors which led to a non-residential area; the doors were not equipped with a lock. This non-compliance was issued with additional action including a voluntary plan of correction (VPC).

On May 19, 2015, during the initial tour of the home, Inspector #550 observed a set of double doors, unlocked with no staff supervising the non-residential area. Upon further inspection, Inspector #148 confirmed the doors to be the same double doors as identified in the October 2014 inspection report.

The double doors are located centrally in the home between the South and North units and are accessible to residents. It was confirmed that the doors are not equipped with a lock and there is a sign on the door indicating that the doors are to be kept closed at all times. Beyond the double doors is a long corridor within which are several utility type rooms, such as laundry, kitchen, staff room, storage and maintenance. Each of these rooms were equipped with a door and found to be closed and locked when unsupervised.

In addition, at the end of the corridor is a door leading to the outside which is equipped with a lock and audible alarm system; this door was observed to be propped open with bypass engaged for the purposes of receiving supplies; the door is also used as an entrance/exit for staff. The corridor itself is used as a storage area whereby boxes, linen carts, laundry bins, buckets and other miscellaneous items are found from time to time. There are postings within the corridor including staff information related to health and safety, employment opportunities and infection

control.

At no time during observations of this area, were residents observed to be in the area beyond the double doors, nor is there a space in which residents may congregate or would otherwise need to access.

Inspector #148 discussed the non-compliance of October 2014 and the current status of the double doors and area beyond the doors, with the home's Administrator. The home's Administrator indicated that upon discussion with representatives of the licensee, it was determined that the double doors did not require a lock as each door within the corridor, i.e the doors leading to the mechanical room, staff room or laundry, were kept closed and locked when not supervised. Upon further discussion, the home's Administrator described the area beyond the double doors to be a residential area, indicating that on occasion a resident may access the corridor to drop off clothes to be labelled or to seek out a maintenance staff member. Inspector #148 spoke to maintenance staff #S110 and Laundry aid #S138, both of whom are regularly in this corridor, and who reported that residents do not use the corridor.

The double doors, as described above, lead to a non-residential area whereby the double doors are to be equipped with a lock and kept closed and locked when not supervised.

Further exasperating the risk to residents is the door, located at the end of this corridor, that leads to the outside that was found to be unlocked on two separate occasions. During the initial tour of the home by Inspector #550 on May 19, 2015 and an additional observation by Inspector #545 on May 20, 2015, the door leading to the outside of the home, located at the end of the corridor described above, was found to be unlocked.

The home's Administrator was made aware of these observations on May 20, 2015. On the morning of May 21, 2015, Inspector #148 was approached by the Administrator to review the door leading to the outside, as he was unable to identify any issues with the locking mechanism. In the presence of the Administrator and Maintenance staff #S110, it was found that at times when the door is not pulled closed, the magnets located at the top of the door do not touch. When this occurs the distance between the magnets is sufficient to produce the current required to engage the magnetic lock system, whereby the door is closed, appears to be locked and the alarm is engaged. However, given that the magnets are centimeters apart the door is

not in fact locked. When in this position, the door can be pushed open, at which time the alarm sounds. This was consistent with the observations made by Inspectors on May 20 and 21, 2015. Inspector #148 confirmed with the Administrator and Staff #S110 that adjustments were made to the magnets to ensure the door is secure.

As indicated by the grounds, the corridor beyond the double doors is not used or maintained as a resident area. The corridor itself is used as storage for various items posing potential hazards for falls and risk of injury to residents. In addition, at the time of the inspection a potential risk also existed related to the unlocked door leading to the outside of the home. The double doors and corridor are centrally located in the home and are accessible to residents who are able to mobilize on their own. In October 2014, the home previously, and correctly, identified the area beyond the double doors to be non-residential; the double doors were found to not be equipped with a lock and additional action including the VPC was issued. Post October 2014, the home has not equipped the double doors with a lock.
(148)

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

Aug 10, 2015(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan with
strategies for achieving compliance to meet the requirement that at least one registered nurse who is both an employee and a member of the regular nursing
staff of the home is on duty and present in the home at all times, except as provided for in the regulations. The plan shall also include all recruiting and retention strategies.

This plan must be submitted in writing to Melanie Sarrazin, LTCH Inspector at
347 Preston Street, 4th floor, Ottawa, Ontario K1S 3J4 or by fax at 1-613-569-
9670 on or before June 18, 2015.

Grounds / Motifs :

1. The licensee did not ensure that at least one registered nurse who is both an employee of the
licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations 2007, c. 8, s. 8 (3). (Log # O-001154-14)

A complaint was submitted to the Ministry of Health and Long Term Care on October 8, 2014, regarding a lack of nursing staff.

Woodland Villa is a 111 bed Long-Term Care Home in Long Sault. The Registered nursing staffing schedule from March 13 to May 27, 2015 was reviewed. As per the reviewed schedules, there was no Registered Nurse on duty and present in the home for the following 13 shifts:
March 17, 20, 30, 2015, there was no RN present on the night shift.
April 1, 6, 7, 8, 9, 12, 17, 23 and 28, 2015, there was no RN present on the night

shift.
April 26, 2015, there was no RN present on the evening shift.

On May 28, 2015, the DOC confirmed to Inspector #592 that on the above dates, there was no RN on duty and present in the home. The DOC stated that there were Registered Practical Nurses present on site and a Registered Nurse available by telephone when the home was not able to fill the RN shifts. When the staffing plan was reviewed with the DOC, it was reported that the home will attempt to contact all available RNs, on staff, to fill a vacant shift. If the home is unsuccessful an RPN will be contacted to replace the RN shift. She further added that the home did struggled a few weeks ago filling the Registered Nurse night position due to an unexpected temporary leave of two staff members. She further indicated that the home has recruited four RN's to ensure that Registered Nurse shifts are covered.

Under O.Reg. 79/10, s. 45. (2) an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.In an interview with the DOC it was confirmed that on the dates identified above, there was no unforeseen situation of a serious nature that prevented a Registered Nurse who was schedule from getting to the long-term care home.

The licensee did not ensure that there was a registered nurse on site at all times, in the long-term care home. [s. 8. (3)] (592) (592)

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

Sep 01, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29 day of July 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON - (A1)

Service Area Office /
Bureau régional de services : Ottawa