Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2017	2016_414110_0012	033358-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

YORK REGION MAPLE HEALTH CENTRE
10424 Keele Street Maple ON L6A 2L1

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

DIANE BROWN (110), JANET GROUX (606), SIMAR KAUR (654)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 30, 2016, December 01, 02, 07, 08, 09, 14, 15, 19, 20, 21, 22, 23, 29, 30 and January 04, 2017.

The following complaint was inspected during this RQI
Log# 002747-15 -related to provision of care and duty to protect.
The Following critical incidents were inspected.
Log #001849-15- related to resident to resident abuse.
Log #009657-14 -related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED) Director of Care (DOC), Associate Director of Care (ADOC), Nurse Managers (NM), Registered Dietitian (RD), Supervisor of Care, Supervisor of Programs and Services Residents' Council President, Family Council President, Food Service Manager (FSM), Food Service Supervisor (FSS), Registered Nursing Staff, Personal Support Workers (PSW), Food Service Workers FSW), Housekeeping Aides, Activation Aide, Private Care Giver and Residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

11 WN(s)
8 VPC(s)
0 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.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, is fully respected and promoted.

Review of a Critical Incident (CI) report, dated for an identified date in 2014, reported an allegation of staff to resident abuse.

Review of a letter dated for an identified date in 2014, written by a direct care staff member, revealed that on an identified day in 2014, an identified resident had verbalized he/she was in pain, wanted to be transferred to the hospital for further assessment and requested to see a Registered staff member. It was reported that the Registered staff member called the resident from the two way nurse call system located at the nursing station and connected to the resident's room. It was further reported that the Registered staff member was overheard stating to the resident that he/she was not in pain and he/she was not going to send him/her to the hospital.

The direct care staff member stated he/she observed the identified resident to be very upset and scared and was requested by the resident not to leave him/her alone.

Interview with the resident was not conducted due to the resident's cognitive impairment.

Interview with a direct care staff member revealed he/she went to the nursing station to inform the Registered staff member that the resident requested to see him/her. The direct care staff member stated the Registered staff member told him/her that he/she was not going to see the resident but would speak to the resident on the nurse call system. The direct care staff member stated he/she returned to the residents’ room and observed the resident speaking to the Registered staff member through the nurse call system speaker located beside the resident's bed. The direct care staff member stated he/she overheard the Registered staff member tell the resident that he/she will not be coming to see him/her because he/she was not in pain and he/she was not going to transfer him/herself out for assessment.

The inspector was unable to contact the Registered staff member as he/she was not available for an interview.

Interview with the previous ADOC and DOC revealed all staff are expected to treat residents with respect and courtesy and stated from the investigation, the home concluded that the Registered staff member failed to treat the resident in this manner. [s. 3. (1) 1.] (606)

2. The licensee failed to ensure the resident's right to have his or her participation in decision making is fully respected and promoted.

Review of a CI report, dated for an identified date in 2014, reported an allegation of staff to resident abuse.

Review of a letter dated for an identified date in 2014, by a direct care staff member revealed that on an identified date in 2014, an identified resident had verbalized he/she was in pain and wanted to go to be transferred out of the home for a hospital and requested the Registered staff member to see him/her. It was reported that the Registered staff member called the resident from the two way nurse call system located at the nursing station and connected to the resident’s room and was overheard stating to the resident that he/she was not in pain and was not going to send him/her to get an assessment. The direct care staff member stated he/she observed the resident to be very upset and scared and was requested by the resident not to leave him/her alone.

Review of the residents' Minimum Data Set (MDS) assessment, indicated the resident's cognitive skills for daily decision making was noted to be consistent and reasonable.

The inspector was unable to contact the Registered staff member as he/she was not available for an interview.

Interview with the Registered staff member revealed staff are expected to follow up on a resident's request to assist them in their decision making.

The previous DOC stated that from the home's investigation, the Registered staff member did not listen to the resident's request to be transferred for an assessment.

The resident's right to participate in decision making, regarding his/her care, was not respected. [s. 3. (1) 9.] (606)

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's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Review of CI report from an identified date in 2014 reported an allegation of staff to resident abuse.

Review of a letter dated in an identified date in 2014, by a direct care staff member revealed that in an identified month in 2014, a resident had verbalized he/she was in pain and wanted to go to the hospital for an assessment and requested the Registered staff member to see him/her. It was reported that the Registered staff member called the resident from the two way nurse call system located at the nursing station and connected to the resident's room and was overheard stating to the resident that he/she was not in pain and was not going to send him/her for an assessment. The direct care staff member stated he/she observed the resident to be very upset and scared and was requested by the resident not to leave him/her alone.

Review of the resident's plan of care indicated a focus for pain management.

The inspector was unable to contact the Registered staff member as he/she was unavailable.

Interview with the previous ADOC stated the Registered staff member did not respond to the residents' needs and did not provide the care as required. [s. 6. (7)] (606)

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

Review of a CI report, dated for an identified date in 2014, reported an allegation of staff to resident abuse.

Review of the home's policy entitled, "Pain Management Program", revised July 2015, indicated that when pain was identified, a formal comprehensive questionnaire or set observations is conducted by a registered nursing staff member in order to determine the type and level of pain and to develop guidelines for implementation of pain management strategies. Pain assessments in both homes will be completed when a resident self identifies or is identified by anyone as having unmanaged pain. Pain may be identified by a resident, a staff or family member and reported verbally to the Registered nursing staff.

Review of the resident's progress notes indicated an identified resident was started on antibiotics on an identified date in December, 2014, for a medical condition.. On an identified day in December, 2014, it was documented that the resident was drowsy and had decreased intake at meal time. On another identified date in December, 2014, the resident complained of pain to two identified areas and had requested medication. On an identified date in December, 2014, it was documented the resident received medication as resident was restless unable to settle.

Review of the residents' Point Click Care (PCC) assessments did not indicate that a pain assessment had been completed after the resident had begun verbalizing pain.

An interview with the resident was not conducted due to the resident's cognitive impairment.

Interview with a direct care staff member revealed that the resident had activated his/her call bell and had requested the Registered staff member come see her in his/her room as he/she was in pain and wanted to be transferred out of the home for assessment. The direct care staff member stated he/she informed the Registered staff member that the resident had verbalized he/she was in pain and stated the Registered staff member did not go to see the resident.

Interview with the Registered staff member, ADOC and DOC revealed staff are

responsible to go and see the resident who had verbalized pain and complete a pain assessment.

The inspector was unable to contact the Registered staff member as he/she was not available.

Interview with the previous ADOC and DOC revealed the registered staff are expected to see the resident and complete a pain assessment when the resident is verbalizing or exhibiting a change in their condition and confirmed this was not done. [s. 6. (10) (b)] (606)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Review of a CI report, submitted to the Ministry of Health and Long-Term Care

(MOHLTC) on an identified date in 2015, indicated abuse of a resident by another resident.

Further review of the CI report indicated on an identified date in 2015, resident A was observed to be in an identified manner with resident B.

A second CI report was submitted to the MOHLTC on an identified date in 2015, that indicated abuse of resident B by resident A. Further record review of the second CI report indicated that in 2015, resident A was found in an identified manner with resident B by a PSW.

Record review of resident B's risk management report dated an identified date in 2015, indicated resident A was seen in an identified manner with resident B by a family member of another resident. Further review of the risk management reports indicated the second incident in 2015, where resident A was found in an identified manner with resident B by a direct care staff member.

Resident B was not interviewable and his/her MDS indicated cognitive impairment.

Interview with a direct care staff member and Registered staff members revealed resident A had history of identified responsive behaviours which involved staff and other residents. The above mentioned staff further indicated resident B had additional identified responsive behaviours.

Record review of resident A's plan of care and interview with a Registered staff member confirmed the resident's written plan of care did not indicate his/her identified responsive behaviours. Further review of his/her written plan of care revealed that there was no identification of his/her identified responsive behaviours after the incident with resident B.

Interview with a family member of an identified resident confirmed that he/she observed resident A in an identified manner with resident B. He/she further indicated he/she reported the incident to a housekeeping staff in the home.

Interview with the housekeeping staff denied that he/she had witness above mentioned incident.

Interview with a direct care staff member confirmed that he/she observed resident A exhibiting an identified responsive behaviour toward resident B on an identified date in

2015. The direct care staff member further indicated that he/she separated both residents, and notified a Registered staff member.

Interview with the Registered staff member indicated that he/she was notified by a direct care staff member about above mentioned incident. The Registered staff member stated a risk management report was completed on an identified date in 2015, regarding the abuse incident from resident A to resident B. The Registered staff member further revealed that there was no injury to resident B.

Interview with direct care staff, family member of another identified resident, and the Administrator confirmed resident A was abusive toward resident B two times in 2015. [s. 19. (1)] (654)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents were protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI report was submitted to the MOHLTC on an identified date in 2015, indicating abuse of resident B by A.

A second CI report, was submitted to the MOHLTC on an identified date in 2015, indicating abuse of resident B by resident A occurred in 2015.

Record review of resident A's progress notes and risk management reports indicated on five occasions in 2015, the resident had identified inappropriate responsive behaviours.

Record review of resident A's plan of care revealed that his/her identified inappropriate responsive behaviour had not been identified on his/her plan of care.

Interview with a direct care staff members and Registered staff members revealed resident A had a history of identified inappropriate behaviour that included the involvement of staff and other residents. Further interview with the Registered staff member confirmed the resident's identified inappropriate responsive behaviour had not been identified on his/her plan of care.

Interview with the Supervisor of Care and the lead for the home's responsive behaviour program indicated resident's plan of care should have been based on an interdisciplinary assessment of the resident that included mood and behaviour patterns and, any identified responsive behaviours. He/she further confirmed resident A's plan of care had not based on an interdisciplinary assessment of the resident and did not identify his/her identified inappropriate responsive behaviour as required. [s. 26. (3) 5.] (654)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on an interdisciplinary assessment of the resident includes mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

An identified resident was triggered in the Resident Quality Inspection (RQI) for skin and wound.

Record review of the resident's Minimum Data Set (MDS) assessment on an identified date indicated impaired skin integrity.

Record review of residents' plan of care's indicated an identified area of impaired skin integrity.

Review of the resident's progress notes revealed that he/she has a history of reoccurring issues with impaired skin integrity. Progress notes further indicated that the resident redeveloped an area of impaired skin integrity on an identified date.

Record review of home's policy on Skin and Wound Program, (Policy #3, titled Registered Nursing staff responsibilities for altered skin) indicated when registered nursing staff are made aware of a newly discovered skin or wound issue they are responsible to conduct at minimum a weekly Skin and Wound assessment found in PCC.

Record review of the residents' skin assessments from PCC indicated that there was no weekly skin assessments on two identified days.

Interview with the Registered staff member and direct care staff member indicated that the resident had impaired skin integrity. Staff further revealed that the resident had a history of impaired skin integrity.

Interview with the Supervisor of Care and the home's lead of the Skin and Wound Care Program indicated the home's process for residents with impaired skin integrity was residents were required to be reassessed weekly by a registered staff. He/she further confirmed that the resident had impaired skin integrity and had not been assessed for two dates in an identified month in 2016. [s. 50. (2) (b) (iv)] (654)

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident's pain was not relieved by initial interventions, is the resident assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

An identified resident was triggered in the RQI for pain management.

Record review of an identified resident’s MDS indicated that he/she had moderate pain daily.

Record review of the resident’s plan of care indicated to administer pain medication as per Medical Director’s (MD) orders and note the effectiveness, acknowledge presence of pain and discomfort, listen to the resident’s concerns and document/report complaints & non-verbal signs of pain.

Interview with the resident revealed that he/she had an identified area of pain for the past two years, took pain medication and that he/she did not think his/her pain was well managed.

Interview with a direct care staff member and a Registered staff member confirmed the resident frequently complained of an area of pain and frequently received pain medication as ordered. A Registered staff member confirmed that the resident received a pain assessment on an identified date on an identified date and had not been reassessed for pain.

Record review of the resident's pain assessments indicated that there was no pain assessment after the identified date.

Interview with the Supervisor of Care and the lead of pain management program indicated that according to the home’s practice, residents with unrelieved pain should be assessed using the home’s pain assessment instrument. He/she further confirmed that the resident was required to be assessed for pain after the identified date of pain and further confirmed the resident had not been assessed as required for his/her unrelieved pain. [s. 52. (2)] (654)

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 when resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the followings were developed meet the needs of residents with responsive behaviors: Written approaches to care including screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Record review of home's policy titled Care of the Residents with Confusion (RC-0602-00, dated 09, December, 2009, Section: Care Routines) did not indicate written approaches to care for residents with responsive behaviors including screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours.

Interview with the Supervisor of Care and lead for the home's responsive behaviour program revealed that the home was revamping their policy for the responsive behaviours program. He/she further confirmed that the above mentioned policy did not indicate written approaches to care for residents with responsive behavior including screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. [s. 53. (1) 1.] (654)

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 written approaches to care for residents with responsive behavior including screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure there was an individualized menu developed for the resident if their needs cannot be met through the home's menu cycle.

Observations of resident #022 at an identified meal on an identified date, identified the resident being served a food item. On a second occasion the inspector observed the resident requesting this food item when menu choices were offered by staff.

Record review of resident's plan of care identified the resident was on an identified diet and was to be offered substitutes for uneaten foods. In addition, staff were to add one serving of an identified item and one serving of another item at at breakfast and allow item A on Tuesdays and Thursdays and item B on Saturdays at lunch.

Staff interview with FSW revealed the resident usually took the same food item. FSW revealed the resident had identified food preferences and that staff offer the menu options but he/she does not choose the items. FSW revealed he/she had been making this food item for the resident at an identified meal for the past several months and that the resident no longer eats item B. FSW revealed the resident just took this food item at another identified meal.

Staff interview with direct care staff member revealed the resident usually took the one identified food item and was no longer eating a item B at meals. The direct care staff member revealed that the resident has forever refused the menu and that he/she has always known the resident to not eat anything from the menu. The direct care staff member revealed the resident's typical meal is one food item, that the resident did not always eat it and that the resident had refused item A and B for the last several months. The direct care staff member stated the resident does not choose items from the menu and that he/she just ate the one food item. Finally, the direct care staff member revealed that the resident was picky about the food that the resident liked his/her an identified food prepared a certain way, but at the home they gave the resident a different style of an identified food.

Record review of the food production system failed to identify an individual menu for the resident.

An interview with the home's RD identified that he/she prepared an individualized menu for residents when a resident's intake restricts food groups; does not include dairy products or drinking milk; does not include fruit and vegetables or if a resident was limiting their choices. The RD confirmed an individualized menu would be required for the resident and had not been developed. [s. 71. (5)] (110)

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 there is an individualized menu developed for residents if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the director: Abuse of resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A CI report was submitted to the MOHLTC on an identified date in 2015, indicating abuse of resident B by resident A that occurred in 2015. Further review of the CI report indicated that in 2015, resident A was found in an identified manner with resident B, by a direct care staff member.

Record review of resident B's risk management reports indicated a second incident in 2015, whereby resident A was found in an identified manner with resident B by a direct care staff member.

Interview with a direct care staff member confirmed that he/she observed resident A in an identified manner with resident B in 2015. The direct care staff member further indicated that he/she separated both residents.

Interview with a Registered staff member indicated that he/she was notified by a direct care staff member about the above mentioned incident. The direct care staff member further indicated that he/she had completed a risk management report for resident B in 2015, for abuse from resident A towards resident B. The Registered staff member further confirmed that he/she did not inform the management about the incident as there was no injury to resident B.

Record review of the home's training record on zero tolerance of resident abuse and neglect indicated that the Registered staff member completed his/her training on an identified date in 2015.

Interview with the ED confirmed the incident mentioned above occurred on the identified day in 2015, and the home did not report to the MOHLTC until a later date in 2015. He/she further indicated that the incident was not brought to the home's management's attention when it occurred on the identified date in 2015. [s. 24. (1)] (654)

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review of the November, 2016, Residents' Council meeting minutes identified a resident concern that staff speak very loudly at night. The concern was again identified in the minutes of December, 2016. Review of the minutes and records provided failed to identify evidence of a written response to the concern identified at the above mentioned meetings.

An interview with the President of Residents' Council revealed that responses to concerns or recommendations are provided verbally to him/her and not in written form.

An interview with the Supervisor of Programs and Services, assistant and liaison between the Residents' Council and the home, confirmed that a written response had not been provided to Residents' Council related to the concern expressed at the November, 2016, meeting. [s. 57. (2)] (110)

WN #11: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

Review of a CI dated for an identified date in 2014, reported an allegation of staff to resident abuse regarding an identified resident.

Review of the residents' Point Click Care (PCC) indicated the residents' substitute decision maker was a third party for decision related to his/her care and finance. It further indicated that the resident had a relative who was also involved in his/her care.

Interview with a Registered staff member revealed staff notified either the third party or the resident's relative depending on what the issues were.

Interview with the previous ADOC and DOC stated the home's practice was to notify the SDM regarding incidents like this. They confirmed the home did not call the third party because the third party was not very involved in the resident's care and therefore was not notified of the above incident. [s. 97. (1) (a)] (606)

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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Issued on this 27th day of February, 2017

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

Original report signed by the inspector.