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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Apr 19, 2017	2017_378116_0005	004009-17	Resident Quality Inspection

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue Woodbridge ON L4L 1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court Woodbridge ON L4L 9T3

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

SARAN DANIEL-DODD (116), NICOLE RANGER (189), ROMELA VILLASPIR (653), 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): February 27, 28. March 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 2017.

The following critical incident system (CIS) inspections were conducted concurrently with the Resident Quality Inspection (RQI):
Log #'s 028749-16, 029079-16 (related to falls prevention), log#'s 029292-16, 000226-17 (related to injury of unknown cause), Log #'s 027609-16, 000172-17 (related to improper treatment) and Log #023043-16 (related to reporting and complaints).

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the medical director, executive director (ED), director of nursing (DON), associate DON (ADON), registered dietitian (RD), environmental services manager, director of resident and family services, resident assessment instrument (RAI) coordinator, back-up RAI coordinator, registered nursing staff, personal support workers (PSWs), physiotherapist, restorative care aide, recreation staff, housekeepers, laundry aides, Residents' Council President and Family Council president, residents, substitute decision makers (SDMs) and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **11 VPC(s)**
- **1 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. 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 resident #026 was protected from abuse by anyone and not neglected by the licensee or staff.

During record review of resident #026 progress notes, the inspector reviewed multiple documented incidents of inappropriate behaviour by resident #027 directed towards resident #026 and two other identified residents during a specified period.

The inspector was not able to obtain any evidence from the home that they established whether resident #026 had the capacity to provide consent and whether consent was provided in any of the documented incidents.

The inspector interviewed RN #131 who witnessed the incidents that occurred on three separate dates. RN #131 reported that resident #026 is unaware of his/her actions and is not able to give consent due to severe cognitive impairment.

PSW #157 was interviewed regarding an incident that occurred on an identified date which he/she witnessed. PSW reported that resident #026 was not aware of the actions taken and unable to provide consent for the incident. PSW #157 also reported that they witnessed resident #026's inappropriate behaviour toward resident #027.

RN #158 who witnessed two separate incidents was interviewed. RN #158 reported that resident #026 is unaware of his/her actions and is not able to give consent due to severe cognitive impairment.

PSW #128 and PSW #156 were interviewed and they reported that they are aware of and witnessed resident #027's inappropriate behaviour toward resident #026.

Interviews with PSWs #128, #156, #157, RN #158, #131, and the DOC reported that the only strategies to manage resident #027's identified behaviour is to monitor and redirect the resident when the behaviour is witnessed. The licensee failed to protect resident #026, resident #033 and resident #034 despite a known pattern of an identified behaviour of resident #027. [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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully communicated and promoted: 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.

On an identified date, inspector #189 observed resident #032 to be dressed inappropriately.

Interview with PSW #154, who is the primary PSW for the resident, revealed that he/she provided care to the resident and applied his/her clothing. After being dressed, the resident went to the dining room. After meal service, the PSW reported he/she observed the resident going into his/her room but he/she did not follow up with the resident. The PSW reported that the resident will change articles of clothing on his/her own if he/she does not like the chosen clothing. Interview with RN #155 revealed that he/she was informed that the resident was observed in an identified area of the home inappropriately dressed. RN #155 reported that he/she went into resident #032's room, where he/she observed PSW #154 in the room folding an article of clothing that was applied to him/her after care was rendered. RN #155 reported he/she asked the PSW what the resident is wearing, when PSW #154 reported that the resident will change his/her clothing and it is his/her right to wear whatever he/she wants. RN #155 stated that the PSW then placed the article of clothing into the residents' closet.

Interview with RN #155 and discussion with the E.D. confirmed that the resident was inappropriately dressed, and that the resident's dignity was not respected. [s. 3. (1) 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 following rights of residents are fully communicated and promoted:

- 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

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

During stage one of the RQI, resident #001 triggered for continence care to be further inspected.

The written plan of care for resident #001 indicates the resident is continent. The incontinent product summary list documents the resident requires an identified product during specified shifts.

The quarterly resident assessment instrument minimum data set (RAI-MDS) assessment completed on an identified date, indicates a specified level of incontinence and the required use of an identified product.

An interview held with PSW #107 indicated that the resident is usually continent during an identified shift and requires the use of the identified product during specified shifts. Interviews held with RN #'s 106 and #130 indicated that the resident has been assessed to require the use of the identified product during the identified shifts and at times will request to have the identified product.

Further interview held with RN #130 and the DOC confirmed that the written plan of care does not set out clear directions to staff and others who provide direct care to the resident in relation to incontinence needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The home submitted a CIS on an identified date reporting an incident an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Record review of resident #045's progress notes revealed that PSW #135 turned away to obtain an item for the resident when the resident fell. Resident #045 sustained an injury to an identified location of his/her body and was transferred to the hospital.

Record review of resident #045's written plan of care indicated he/she required limited assistance and supervision with one staff member for transfers. Record review of the resident's transfer logo by his/her bedside revealed he/she required minimum assistance with one staff member for transfers. Record review of resident #045's resident assessment instrument-multiple data set (RAI-MDS) quarterly assessments over two specified periods, indicated he/she required extensive assistance with two or more persons for transfers.

During an observation conducted on an identified date, resident #045 was observed to be transferred from an identified mobility device to an identified location by two PSWs.

Interviews with PSW #135 and RPN #106 stated that resident #045 normally required one staff assistance during transfers however, at times two staff would have to carry out the transfer. Interview with RPN #106 revealed he/she was aware that resident #045 required two staff during transfers from time to time. He/she further indicated that a referral to the physiotherapist (PT) should have been made when the direct care staff noted a change in the resident's transfer status.

Interview with the PT stated he/she was not aware that staff have been transferring resident #045 with two person assistance. The PT further indicated if he/she had received a referral from the nursing staff, then he/she could have re-assessed the resident accordingly and determine the appropriate transfer status. The PT acknowledged that collaboration did not occur between physiotherapy and the nursing team.

Interview with the DOC stated that the home's expectation was for communication to happen between interdisciplinary teams, and that the staff collaborate with one another in the assessment of the resident. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of so that different aspects of care were integrated and were consistent with and complemented each other.

During a meal observation on an identified date, the inspector observed an identified individual pour an identified fluid into resident #024's prescribed therapeutic fluid intervention, and proceeded to feed the identified fluid to the resident.

Record review of resident #024's written plan of care revealed that resident #024 is at high nutritional risk. The written plan of care directs staff to provide an identified food and fluid regime.

Interview with RN #126, who was present in the dining room and observed the changed consistency of the fluid, informed the inspector that this is not the first occurrence that the identified individual has provided the resident with the incorrect fluid intervention. The RN confirmed that the resident did receive the incorrect fluid consistency however,

reported that the incident was not communicated to the Registered Dietitian (RD). Interview with the RD confirmed that the dietary team was unaware of this incident, and should be notified in order to provide teaching to the identified individual and update the resident's written plan of care. Interview with RN #126 and the RD confirmed that the change in the resident's fluid consistency was not communicated to the team. [s. 6. (4) (b)]

4. 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.

The home submitted a CIS to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Record review of resident #044's progress notes revealed that PSW #128 reported to RN #131 that an identified part of his/her body revealed a change of condition. Upon assessment by the RN, the identified area appeared to have changed and documented the assessment. The physician was notified and ordered the resident to be transferred to the hospital for further assessment. The resident's Substitute Decision-Maker (SDM) was notified. Record review of resident #044's diagnostic tests revealed that the resident sustained an identified injury. Record review of the submitted CIS indicated that the cause of the sustained injury had been inconclusive.

Record review of the home's investigation notes revealed that the management team interviewed all of the staff who provided care to resident #044 over a specified period of time prior to being sent to the hospital. It was determined that on an identified date, PSW #134 transferred resident #044 using an identified device, unsupervised. There were no injuries from the incident.

Interview with PSW #127 stated that on an identified date, he/she reported to RPN #132 and RN #133 that an area of resident #044's body revealed a change of condition. Interview with RPN #132 revealed that he/she assessed the area and noted that the area had changed. RPN #132 stated he/she wrote a note in the physician's binder regarding the appearance of the identified area.

Record review of the physician's communication binder, revealed that on an identified date, RPN #132 wrote "PSW reported a change of condition. Record review of the physician's notes in resident #044's chart on an identified date, revealed that there was

no change to the identified area and that the resident was stable.

Record review of resident #044's written plan of care indicated he/she required an identified number of staff to provide total assistance with the identified device for all transfers.

Interview with PSW #134, stated that he/she did not follow resident #044's written plan of care when he/she transferred the resident using the identified device without the assistance of another staff member(s).

Interview with the DOC confirmed that PSW #134 did not provide care to resident #044 as specified in the resident's plan of care. [s. 6. (7)]

5. On an identified date, the home submitted a CIS reporting an incident that caused injury to resident #022 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS was as follows:

On an identified date, resident #022 almost had a fall incident. As per primary PSW, resident was on the toilet and PSW turned away to lower the bed with the intention to put the resident back to bed after toileting. After the bed was lowered, the PSW turned away and saw resident #022 standing and was unstable. The PSW quickly ran over to the resident and caught him/her before he/she was lowered or fell but an area of the resident's body made contact with the counter of the bathroom.

Record review revealed that as a result of the incident that occurred on an identified date, resident #022 sustained injury to specified areas of his/her body. The resident was sent to the hospital for further assessment and provided an identified diagnosis in relation to the injury.

Record review of the medical directives revealed that the resident has an order in place for an identified medication to be administered. The inspector reviewed the resident Medication Administration Record (MAR) for two identified dates, when the staff identified the resident was displaying identified symptoms. Record review identified that the resident did not receive a specified medication, nor did the staff conduct a required assessment. Interview with the DOC confirmed that resident #022 did not receive the specified medication as per order, and that the plan of care for an identified measure was not provided to the resident as specified in the plan. [s. 6. (7)]

6. During an identified meal service, the inspector observed an identified individual pour an identified fluid into resident #024's prescribed therapeutic intervention, and proceeded to feed the fluid to the resident.

Record review of resident #024's written plan of care revealed that resident #024 is at a specified nutritional risk. The plan of care directs staff to provide an identified dietary intervention.

Interview with PSW #142 who was present in the dining room, reported that the prescribed fluid was placed on the table for the resident however, the identified individual told the PSW that they did not want the identified fluid and the identified individual then proceeded to take an identified consistency of fluid and place it in front of the resident. PSW #142 stated being aware that the resident is to receive identified fluids as per the plan of care, however he/she did not mention this to the identified individual, nor did he/she inform the nurse of this incident.

Interview with RN #126, who was present in the dining room and observed the changed consistency of the identified fluid once informed by the inspector, stated that this is not the first occurrence that the identified individual has provided the resident with an identified consistency of fluids instead of the prescribed fluid. The RN confirmed that resident #024 received the incorrect fluid consistency and did not receive the fluid as specified in the written plan of care. [s. 6. (7)]

7. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

During stage one of the RQI, resident #001 triggered for continence care to be further inspected.

The written plan of care for resident #001 indicates that the resident is continent.

The quarterly resident assessment instrument minimum data set (RAI-MDS) assessment completed for a specified period, documents that the resident is occasionally incontinent and requires the use of an identified product.

Interviews held with PSW #107 and RN #'s 106 and 130 indicated that the resident has been assessed to require the use of an identified product during specified periods and at

times will request to have the identified product.

Interviews held with PSW #107, RN staff #'s 106, 130, the back up RAI and RAI coordinator(s) confirmed that the plan of care was not revised when resident #001's continence care needs changed. [s. 6. (10) (b)]

8. During stage one of the RQI, resident #008 was triggered for personal support services involving an identified medical decline.

Record review of resident #008's written plan of care for two separate periods, indicated the resident wears an identified medical device at all times and to ensure the medical device is clean and in good repair.

During two observations on the same date, resident #008 was observed without the medical device.

Interview with resident #008 revealed that resident had not been wearing the medical device for an established time frame. He/she further indicated that he/she stopped wearing the medical device as they did not help. The resident could not recall being assessed further.

Record review of resident #008's diagnosis and interview with RPN #103 revealed that resident #008 had an identified medical condition. Further interviews with PSW #113 and RPN #103 confirmed that resident #008 had not worn the medical device over the course of an identified period, as the resident stated that the medical device did not help any more with the identified impairment. RPN #103 further confirmed that he/she had missed updating the resident's written plan of care when she/ was notified about the change in the resident plan of care.

Interview with RAI Coordinator and the DOC revealed that registered staff were responsible to review and revise resident #008's written plan of care when the resident's care needs changed, and resident #008's written plan of care was not reviewed and revised as required. [s. 6. (10) (b)]

9. The home submitted a CIS to the Director, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Record review of resident #045's progress notes revealed that PSW #135 turned away to obtain an article for the resident when the resident fell. The resident sustained an injury to a specified location of his/her body and was transferred to the hospital.

Record review of resident #045's written plan of care indicated staff were required to apply and remove an identified device during specified times. Record review of the unit information binder on an identified floor that PSWs referred to when providing care to the residents, directed staff to put on resident #045's identified device at established times.

During an observation conducted on an identified date, the inspector noted that resident #045 was not wearing a specified device.

Interview with PSW #135 stated that resident #045 no longer wore the specified device as he/she was no longer ambulating. Interview with RPN #106 confirmed that resident #045 no longer required the specified device as the resident was no longer ambulatory. The RPN confirmed that the resident's plan of care still included the specified device as a fall prevention intervention. He/she further indicated that the resident's plan of care was not updated.

Interview with the DOC stated that the home's expectation was for staff to update and revise the resident's plan of care when there were changes in the resident and when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

10. The home submitted a CIS to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Record review of resident #045's progress notes revealed that PSW #135 turned his/her back to obtain an article when the resident fell. Resident sustained an injury and was transferred to the hospital.

Record review of resident #045's progress note for an identified date, indicated that the PT recommended for the resident to use an identified mobility device. Record review of the resident's written plan of care completed on an identified date, did not indicate any information regarding the use of the mobility device.

Interview with RPN #130 stated that the resident had been using the mobility device since the above-mentioned incident. The RPN confirmed the PT's recommendation for

resident #045 to use the mobility device was not added to the resident's plan of care at that time. The RPN stated that the intervention to use the mobility device should have been included in resident #045's plan of care after it was recommended by the PT. He/she further indicated that the resident's plan of care was not revised when his/her care needs changed.

Interview with the DOC stated that the home's expectation was for staff to update and revise the resident's plan of care when the resident's care needs changed. [s. 6. (10) (b)]

11. During stage one of the RQI resident #011 triggered for skin impairments.

Record review revealed that on an identified date, resident #011 developed a skin impairment to an identified location, which resolved. On an identified date, resident #011 developed a subsequent skin impairment, and treatments ordered to treat the affected area.

Review of the written plan of care on an identified date, revealed there are no interventions related to the subsequent skin impairment. Interviews with RPN #140 and ADOC #102, revealed that when there is a change in the residents skin condition, the registered staff are directed to update the written plan of care with the identified skin conditions and interventions. Interview and review of the written plan of care with RPN #140 and ADOC #102, confirmed that the interventions related to the identified skin impairment was not updated on the written plan of care. [s. 6. (10) (b)]

12. On an identified date, the home submitted a CIS reporting an incident that caused injury to resident #022 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIS was as followed:

On an identified date, resident #022 almost had a fall incident. As per primary PSW, resident #022 was on the toilet and the PSW turned away to lower the bed with the intention to put the resident back to bed after toileting. After lowering the bed, the PSW turned away and saw resident #022 standing and was unstable. The PSW quickly ran over to resident #022 and caught him/her before he/she was lowered or fell but an area of the resident's body made contact with the counter of the bathroom.

Record review revealed that on an identified date, a fall risk assessment was conducted and resident #022 was identified at an identified risk for falls. The inspector reviewed the written plan of care where the fall risk of the resident is identified.

Interview with the back up RAI coordinator #117 and ADOC #102, revealed that when a resident is identified at an identified risk for falls, the registered staff are directed to update the written plan of care with the identified risk level and interventions required. Interview with the ADOC #102 revealed that the written plan of care was updated on an identified date. Interview with RAI- coordinator #117, ADOC # 102 and the DOC confirmed that the resident was identified as a specified risk for falls and the written plan of care was not updated. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following in relation to the plan of care:

- that the plan of care sets out clear directions to staff and others who provide direct care to the resident,
- that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other
- that the care set out in the plan of care is 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 is no longer necessary, to be implemented voluntarily.

WN #4: 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 :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff.

During the initial tour of the home, identified door(s) were observed to be unlocked and these non-residential areas accessible to residents. PSW #147 confirmed that the identified doors should have been locked and proceeded to lock the door.

On identified dates, utility room door(s) which were equipped with locks were found unlocked. PSW #148, #149, RPN #103 and RN #131, confirmed that the doors should have been locked. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff ,or anything else provided for in the regulations that the licensee knows of, or that is reported is immediately investigated.

During stage one of the RQI, prevention of abuse and neglect was triggered for resident #001 to be further inspected.

Resident #001 expressed to inspector #116 that on one occasion, he/she informed PSW #160 that he/she was experiencing discomfort while PSW #160 was providing care. Resident #001 stated that PSW #160 continued to provide care in an identified manner although he/she expressed discomfort. Resident #001 stated that the concerns were reported to staff members on the unit and to the management of the home. Resident #001 indicated that at times he/she feels afraid due to reporting the concerns to the home.

Review of progress note on an identified date, documents the following:
resident #001 approached the back-up RAI coordinator #117 and stated that during a specified shift he/she was not provided with assistance and that an identified staff member stated they cannot provide assistance because there is no time. Resident #001 stated that later on, a staff member provided an identified care task and left him/her in bed. Resident then stated that an identified care task was not provided. Lastly, resident

stated during care that he/she complained of discomfort however, the PSW continued to provide care in an identified manner.

Review of progress notes and interviews held with back-up RAI coordinator #117, staff #141, PSW's #135 and #160 indicated that the assertions of not being provided care to be unfounded. Further investigation was not conducted in regards to resident #001's assertions of improper care.

Review of progress note for an identified date, documents that an identified individual reported that resident #001 was found with altered skin integrity and expressed concerns with PSW staff #159. The identified individual insinuated the resident is not capable of self inflicting the altered skin integrity and requested an investigation.

Review of the home's written and verbal complaint log document the date of complaint and the date of follow up with the complainant. The complaint log indicates that an identified PSW was changed due to expressing concerns and per resident #001's request.

Record review and interviews held with PSW #159 and the DOC provided conflicting information. An interview held with PSW #159 revealed that he/she was not aware of or had knowledge of concerns related to improper care of resident #001 and was not informed about the concerns by management. An interview held with the DOC and the E.D. indicated that the concerns related to improper care were investigated however, they could not provide any documentation to support that the concerns were immediately investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff ,or anything else provided for in the regulations that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #6: 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 any person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident and/or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

During stage one of the RQI, prevention of abuse and neglect was triggered for resident #001 to be further inspected.

Resident #001 expressed to inspector #116 that on one occasion, he/she informed PSW #160 that he/she was experiencing discomfort while PSW #160 was providing care. Resident #001 stated that PSW #160 continued to provide care in an identified manner although he/she expressed discomfort. Resident #001 stated that the concerns were reported to staff members on the unit and to the management of the home. Resident #001 indicated that at times feels afraid due to reporting the concerns to the home.

Review of progress note on an identified date, documents the following:
resident #001 approached the back-up RAI coordinator #117 and stated that during a

specified shift he/she was not provided with assistance and that an identified staff member stated they cannot provide assistance because there is no time. Resident #001 stated that later on, a staff member provided an identified care task and left him/her in bed. Resident then stated that an identified care task was not provided. Lastly, resident stated during care that he/she complained of discomfort however, the PSW continued to provide care in an identified manner.

- Review of progress note for an identified date, documents that an identified individual reported that resident #001 was noted with an identified injury and expressed concerns with a particular PSW. The identified individual insinuated that resident #001's was not capable of injuring himself/herself and requested an investigation to be done.

Interviews held with back-up RAI coordinator #117 and staff #141 indicated that the resident's concerns were brought forward to the DOC. An interview held with the DOC and the E.D. revealed that the suspicion(s) of improper care, abuse and neglect of resident #001 which occurred on two identified dates were not immediately reported to the Director. [s. 24. (1)]

2. During record review of resident #026 progress notes, the inspector reviewed multiple documented incidents of a identified responsive behaviour by resident #027 directed towards resident #026 and two identified resident's.

Interviews with PSW's #128, #156, #157 and RN's #158, #131, revealed that they have witnessed resident #027 identified behaviour towards resident #026 and other co residents on the unit, and that the only strategies to manage resident #027's identified behaviour is to monitor and redirect the resident when the behaviour is witnessed. Record review and interview with the DOC confirmed that these incidents constitutes abuse, however the home did not notify the Director of these incidents. [s. 24. (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 any person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident and/or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #7: 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:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of an identified organ system.

During stage one of the RQI, resident #008 was triggered for personal support services involving an identified medical decline.

Record review of resident #008's written plan of care for two separate periods, indicated the resident wears an identified medical device at all times and to ensure the medical device is clean and in good repair.

During two observations on the same date, resident #008 was observed without the medical device.

Interview with resident #008 revealed that resident had not been wearing the medical device for an established time frame. He/she further indicated that he/she stopped wearing the medical device as they did not help. The resident could not recall being assessed further.

Record review of resident #008's diagnosis and interview with RPN #103 revealed that resident #008 had an identified medical condition. Further Interviews with PSW #113 and RPN #103 confirmed that resident #008 had not worn the medical device over the course of an identified period, as the resident stated that the medical device did not help any more with the identified impairment.

Interview with RAI coordinator #118 and RPN #103 revealed that they could not locate any assessment records for resident #008's identified medical condition for an identified period.

Interview with RAI coordinator #118 and the DOC confirmed that as per the home's expectations the resident's plan of care should be based on an interdisciplinary assessment of the resident's identified impairment. They further confirmed that resident #008's plan of care was not based on an interdisciplinary assessment of his/her identified medical impairment as required. [s. 26. (3) 4.]

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 plan of care is based on an interdisciplinary assessment of resident #008's identified medical impairment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

The home submitted CIS to the Director, related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

Record review of resident #044's progress notes revealed that PSW #128 reported to RN #131 that an identified part of his/her body revealed a change of condition.
The physician was notified and ordered the resident to be transferred to the hospital for further assessment. The resident's Substitute Decision-Maker (SDM) was notified.
Record review of resident #044's diagnostic tests revealed that the resident sustained an identified injury. Record review of the submitted CIS indicated that the cause of the sustained injury had been inconclusive.

Record review of the home's investigation notes revealed that the management team interviewed all of the staff who provided care to resident #044 over a specified period of time prior to being sent to the hospital. It was determined that on an identified date, PSW #134 transferred resident #044 using an identified device, unsupervised. There were no injuries from the incident.

Interview with PSW #127 stated that on an identified date, he/she reported to RPN #132 and RN #133 that an area of resident #044's body revealed a change of condition. Interview with RPN #132 revealed that he/she assessed the area and noted a change to the identified area. RPN #132 stated he/she wrote a note in the physician's binder regarding the area.

Record review of the physician's communication binder, revealed that on an identified date, RPN #132 wrote "PSW reported a change of condition. Record review of the physician's notes in resident #044's chart on an identified date, revealed that there was no change to the identified area and that the resident was stable.

Record review of resident #044's written plan of care indicated he/she required a specified number of staff to provide total assistance with an identified device for all transfers.

Interview with PSW #134, stated that he/she did not follow resident #044's written plan of care when he/she transferred the resident using the identified device without the assistance of the specified number of staff. PSW #134 confirmed that he/she carried out an unsafe transfer.

Interview with the DOC confirmed that PSW #134 carried out an unsafe transfer. The DOC further indicated that the home's expectation was for the required number of staff to be present when transferring residents using the ceiling lift. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #027 demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #027 has a history of exhibiting identified behaviours directed towards co residents. During an interview with RN #131, it was reported that resident #027 would exhibit inappropriate responsive behaviour toward resident #026 and other residents of a specified gender.

During an interview with PSW #157, resident #027 was described as being inappropriate with co residents on the unit. PSW #157 stated that resident #027 will respond inappropriately toward resident #026 and has been found in his/her room. The inspector asked PSW #157 what interventions were in place to manage resident #027's behaviours and PSW #157 indicated that staff were to monitor the resident and redirect the resident and co resident. PSW #157 was unaware of any other interventions to manage resident #027's identified behaviour directed at co residents.

During an interview with PSW #128 and #156, the PSW's reported that resident #027 seemed aware of his/her actions towards the resident, and that resident #026 is likely not cognitively aware enough to understand what resident #027 was wanting to do. Record review indicated that the cognitive performance score (CPS) for resident #026 indicates that the resident is cognitively impaired.

Interview with RN #131 and the DOC indicated that resident #027 does have identified behaviours. The DOC reported that staff are to monitor resident #027's whereabouts and to intervene if resident behaviour is inappropriate. The DOC confirmed that the home was unable to confirm whether resident #026 provided consent to the incidents with resident #027.

Resident #027's written plan of care for an identified date was reviewed. Although there are interventions related to the resident's expressiveness, the written plan of care related to the expressiveness was last revised two years prior. All staff interviewed indicated that the interventions to manage resident #027 behaviour were to monitor and redirect the resident. There were no other actions taken to respond to the needs of the resident, including assessments, reassessments and interventions to manage resident #027's identified behaviour. [s. 53. (4) (c)]

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 the following for each resident demonstrating responsive behaviours:
- the behavioural triggers for the resident are identified, where possible
- strategies are developed and implemented to respond to these behaviours, where possible and,
- actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for housekeeping, laundry, and maintenance has a post-secondary degree or diploma and knowledge of evidence-based practices and/or prevailing practices as applicable.

Review of the ESM's employee record indicates that they have achieved identified certificates and undergone a specified apprenticeship. The ESM was initially hired in a specified capacity and then transferred to the position of ESM.

During an interview, the ESM stated that he/she has received specified training onsite however, could not provide any supporting documentation and/or knowledge of evidence-based practice and/or prevailing practices related to the role and responsibilities.

Further interview with the ESM and the ED indicated that the agreement upon embarking upon the role was for the ESM to enroll and successfully complete an identified program. As of this inspection, the ESM has not completed all of the identified program. Further interview with the ESM and the E.D. confirmed he/she does not have the required credentials for the designated lead position of maintenance as outlined in the Ministry of Health regulation however, felt he/she was capable of managing the job responsibilities due to being with the organization for a long time. [s. 92. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the designated lead for housekeeping, laundry, and maintenance has knowledge of evidence-based practices and/or prevailing practices as applicable, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

The licensee has failed to ensure that the following devices were not used in the home: sheets, wraps, tensors, or other types of strips or bandages used other than for a therapeutic purpose.

The home submitted a CIS to the Director, related to improper/ incompetent treatment of a resident that resulted in harm or risk to a resident.

Review of the home's video surveillance on an identified date, revealed the following:
- Resident #014 was sitting in a mobility device. Resident had an identified medical device applied and was observed removing the medical device. At an established time, PSW #120 was observed re-applying the medical device on resident #014.
-At an identified time, PSW #121 and RPN #123 were observed re-applying the medical device on resident #014, and both staff covered the medical device with an identified item. The PSW and RPN tucked the ends of the identified item behind an identified area of resident #014.
-At an identified time, the identified item was hanging from the mobility device, and was no longer covering the medical device. Resident #014 removed the medical device. PSW #122 and RPN #123 walked towards the resident. RPN #123 took the identified item and covered the medical device, wrapping the identified item around an identified area of

resident #014. PSW #122 and RPN #123 secured the identified item in an area that was inaccessible by the resident. Both staff left while resident #014 remained in an identified area. The resident was calm and showed no signs of distress.
-At a specified time, the ADOC came to the floor and called PSW #121's attention while pointing to resident #014. The PSW untied the identified item from the mobility device and took the identified item away. Resident still had the medical device applied to an identified area of resident #014.

Interviews with PSW #121 and PSW #122 confirmed the above-mentioned incident. PSW #122 stated RPN #123 told him/her that the purpose of the identified item was to cover the medical device, so that the resident would not pull the medical device out. Interview with RPN #123 confirmed that the identified item was applied to cover the resident's medical device, and was placed in an area that was inaccessible to the resident. The RPN further indicated that the purpose of the identified item was to prevent the resident from removing the medical device and prevent him/her from falling.

Interview with the ADOC and the DOC confirmed the above-mentioned incident. The ADOC and DOC further indicated that the identified item is not allowed to be used as a restraint(s) in the home. [s. 112.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following devices are not used in the home: sheets, wraps, tensors, or other types of strips or bandages used other than for a therapeutic purpose, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Record review of the medication incident reports for an identified date revealed that identified medications that were scheduled for three separate administration times for resident's #028, #029, #030 and #031, were not administered as prescribed by RN #126.

RN #126 signed in the electronic medication administration record (eMAR) that the medications were given as per eMAR, however during the home's investigation, the identified medications were left inside the medication cart.

Record review of the medication incident reports for the above residents, and interview with the DOC, confirmed that the home did not report these medication incidents to the pharmacy or notify the SDM of the above medication incidents. [s. 135. (1)]

2. The licensee has failed to ensure that :
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

Record review of the medication incident reports for an identified date revealed that medications that were scheduled for three separate administration times for resident #028, #029, #030 and #031, were not administered as prescribed by RN #126. RN #126 signed in the eMAR that the medications were given as per eMAR, however during the home's investigation, the medications for the four residents were left inside the medication cart.

Interview with the DOC revealed that a medication management review of all medications incident is discussed and reviewed at the Professional Advisory Committee (PAC). The DOC reported that the medication incidents that occurred on the identified date was reviewed in the PAC meeting however, record review of the PAC meeting minutes and interview with the DOC confirmed that the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review was not conducted. [s. 135. (3)]

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 the following in relation to medication incidents:

Every medication incident involving a resident and every adverse drug reaction is:
- documented, together with a record of the immediate actions taken to assess and maintain the resident's health and,
- reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and,

- a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions
- any changes and improvements identified in the review are implemented; and
- a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

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

On an identified date, the inspector exited the elevator and observed a mobility device along the wall opposite of the elevator. Upon closer inspection, the inspector observed a toolkit with tools located on the seat of the mobility device. The toolkit was unsupervised and had identified items accessible to residents. The inspector observed three recreation staff in the opposite hallway in the corner with an outside vendor. When enquired by the inspector who the items belonged to, the outside vendor confirmed the ownership of the items and that they should not have been left unsupervised.

A review of the home's policy titled "Tools and Equipment", policy # V-A-10.20, revised January 2015, instructs the maintenance staff to ensure the identified items are safely and securely stored at all times. Interview with the ESM confirmed that the toolkit should not have been left unsupervised and accessible to residents. [s. 5.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During a review of the home's medication incident reports for an identified month, the medication incidents revealed that on an identified date, medications that were scheduled for three separate administration times for resident #028, #029, #030 and

#031, were not administered as prescribed by RN #126. RN #126 signed in the eMAR that the medications were given as per eMAR, however during the home's investigation, the medications for the four residents were left inside the medication cart.

A review of the home's pharmacy policy - 6.04 Medication Incident Reporting, revised October 18, 2015, states the home is to submit a copy of the medication incident report to the pharmacy by fax.

Interview with the DOC revealed that for the above medication incidents, the home did not report these medication incidents to the pharmacy, and did not fax the medication incident reports to the pharmacy. The DOC confirmed that the home did not comply with the home's policy for reporting medication incidents to the pharmacy. [s. 8. (1) (b)]

2. The licensee's policy entitled "Repair of Personal Clothing- Uninsured Service-Laundry (policy# XII-I-20.30, revised January 2015) directs staff to remove clothing items requiring repair from circulation and notify the family or responsible party to confirm arrangements for pick up repair.

During stage one of the RQI, family members of resident #010 expressed concern with the condition of clothing upon return from laundry and at times personal articles of clothing are lost or misplaced.

Interviews held with laundry aide staff members #150, 151 and the ESM indicated that damaged clothing is removed from circulation and discarded after an established period of time. Further interview revealed that currently no follow up is conducted to notify the family or responsible party. The ESM confirmed that the homes policy related to repair of personal services was not complied with. [s. 8. (1) (b)]

3. A review of Policy #VII=F-10.20 entitled "Responsive Behaviour – Management" states the following:

Registered staff will:
1. Conduct and document an assessment of the resident experiencing responsive behaviour
2. Complete an electronic Responsive Behaviour Referral to the internal BSO lead/Designate when – there is a new, worsening, or change in responsive behaviours, upon move in of a resident with identified responsive behaviour that poses a risk to themselves or others

3. Refer to available resources in the care community or health care community resources such as Behavioural Support Team (BSO) or Behavioural Interventions Response Team (BIRT) if available, or other similar type community team e.g psychogeriatric resource team and/or psychogeriatric resource consultant (PRC) and RN (EC)
4. Document in the individualized plan of care any measures.

According to resident #027's progress notes and interviews with staff, resident #027 has a history of inappropriate behaviour. Recent incidents of resident #027 displaying inappropriate behaviour directed towards another resident on an identified date.

A review of resident #027's progress notes and chart found no evidence the resident was referred to the behavioural support team (BSO) or the psychogeriatrian as per policy. Interview with RN #131 and the DOC confirmed that the staff notified the physician of resident #027's inappropriate behaviour, however a referral to the BSO or the psychogeriatrian was not completed for the resident's multiple incidents of inappropriate behaviour. [s. 8. (1) (b)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with resident #016 stated that he/she could not recall that members of Resident Council had been asked for the advice in developing and carrying out resident satisfaction survey in 2016.

Record review of Resident Council meeting minutes for 2016 did not indicate that Resident Council had been asked for the advice in developing and carrying out the survey.

Interview with staff #114 revealed that he/she had been assisting in Resident Council and taken meeting minutes of resident council meetings in 2016. Staff further stated that he/she could not recall that the Resident Council had been asked in developing and carrying out satisfaction survey, and in acting on its results in 2016.

Interview with the Director of Resident and Family Services (DRFS) indicated that he/she could not recall that the Resident Council had asked for the advice in creating and carrying out the survey.

Interview with the ED indicated that as per home's expectation the home should involve the council in developing and carrying out the survey by presenting the council with a draft of the survey, and record should be kept in the meeting minutes. The ED and the DRFS further confirmed that the home had no record of involving resident council in the development, carrying out and acting on the survey's results for 2016. [s. 85. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

During stage one of the RQI observation of home's secure unit, a half filled unlabelled spray bottle indicated a specific disinfectant was observed sitting on resident #007's bathroom counter top.

Interview with PSW #108 confirmed that the above mentioned spray was sitting on resident #007's bathroom counter top, and it should not had been left in his/her bathroom. The PSW further indicated that identified individuals came to visit him/her every day, and brought the spray today and left in the resident's bathroom.

Interview with an identified individual confirmed that they brought the spray and left it in the resident's bathroom.

Record review of the home's policy titled "Workplace Hazardous Management Information System" (Policy IV-0-10.00, January 2015) stated to ensure that controlled products used by employees or that are under their control are labelled properly and kept inaccessible to residents/clients at all times.

Interview with RPN #111 and DOC indicated that according to the home's expectations all hazardous substances should be kept inaccessible to all residents at all times, and the spray should not be kept in resident #007's bathroom. [s. 91.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detailed as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
An unexpected or sudden death, including a death resulting from an accident or suicide.

On an identified date, the Ministry of Health and Long Term Care (MOHLTC) received a CIS report regarding an unexpected death of resident #023.

The home initiated the CIS report one day after the incident. This is the first time the Director was notified of the incident. During an interview with the DOC, it was stated that the home did not call the Ministry to inform the Director immediately upon becoming aware of the incident of the unexpected death of resident #023, and that the Director was notified of the incident as reported on the CIS. [s. 107. (1) 2.]

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 151. Obstruction, etc.
Every person is guilty of an offence who,
(a) hinders, obstructs or interferes with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties;
(b) destroys or alters a record or other thing that has been demanded under clause 147 (1) (c); or
(c) fails to do anything required under subsection 147 (3). 2007, c. 8, s. 151.

Findings/Faits saillants :

1. The licensee has failed to ensure that every person is guilty of an offence who hinders, obstructs or interferes with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties.

During stage one of the RQI, resident #008 triggered for personal support services involving an identified medical decline.

Record review of resident #008's written plan of care on an identified date, indicated the resident wears an identified medical device at all times and to ensure the medical device was clean and in good repair.

During two observations on the same date, resident #008 was observed without the medical device.

During an interview with RPN #103, it was revealed that resident #008 had a confirmed medical condition. The RPN further confirmed that resident #008 had not worn the medical device over a specified period, as they no longer helped with the identified medical impairment.

Record review of resident #008's progress notes and interview with RPN #103 revealed that there was no record of notifying the resident's family that the resident had not been using the medical device.

During the initial interview with RN #115, he /she had provided an inspector with a handwritten progress note by him/her with an identified date, from resident #008's health records. The note indicated that the resident's SDM had been notified on an identified date. Review of the progress note revealed the absence of the resident's name and time when progress note had been written. The RN further revealed that on the specified date, he/she had spoken to the resident's SDM when he/she was in to visit the resident. He/she had documented on the resident's chart as Point Click Care (PCC) was not working.

Interview with the DOC confirmed that RN #115 had not worked on the specified date in the facility. DOC further indicated that the home had started an investigation and staff #115 had confirmed that he/she had created the document mentioned above after the inspectors inquiry.

During a subsequent interview with RN #115 it was confirmed that the document he/she had provided to inspector was created after the inspectors enquiry. He/she further revealed that RPN #103 had asked him/her to write above mentioned progress note as there was no record of notifying resident #008's SDM for his/her medical device.

During a subsequent interview with RPN #103 it was confirmed that he/she had asked RN #115 to create the document with hand written progress note, and present it to the inspector.

Interview with DOC and the ED indicated that as per home's expectation no staff should hinder, obstruct or interfere with any inspector conducting an inspection. DOC and the ED further revealed that during home's investigation that RN #115 and RPN #103 confirmed that they had falsified records to present to the inspector. [s. 151. (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

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

On an identified date, the inspector observed resident #025 walking back and forth in the hallway near the nursing station holding onto a clear plastic bag that contained two soiled incontinent brief and a bottle of an identified liquid substance bottle inside the clear bag. The inspector brought it to the attention of RN # 131 who immediately took the soiled bag away from the resident. RN #131 informed the inspector that the soiled bag posed an infection control risk to the resident, and that the identified liquid substance bottle was empty. RN #131 stated that the linen carts should be locked at all times, and confirmed that the linen cart was not locked. RN #131 proceeded to lock the linen cart. [s. 229. (4)]

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

Issued on this 30th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAN DANIEL-DODD (116), NICOLE RANGER (189), ROMELA VILLASPIR (653), SIMAR KAUR (654)
Inspection No. / No de l'inspection :	2017_378116_0005
Log No. / Registre no:	004009-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 19, 2017
Licensee / Titulaire de permis :	FRIULI LONG TERM CARE 7065 Islington Avenue, Woodbridge, ON, L4L-1V9
LTC Home / Foyer de SLD :	VILLA LEONARDO GAMBIN 40 Friuli Court, Woodbridge, ON, L4L-9T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANNETTE ZUCCARO-VANIN

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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).

Upon receipt of this order the licensee shall,

1. Develop and submit a plan that includes the following requirements and the person responsible for completing the tasks:
2. Provide re-education and training to all staff in the home on the home's policy to promote zero tolerance of abuse and neglect of residents.
3. Ensure all staff are educated on how to identify and report resident to resident abuse.
4. Ensure that any resident exhibiting identified behaviour(s) is assessed for consent and interventions are implemented to ensure safety of co residents.
5. The policy review and training shall include all definitions of abuse, and not be limited to resident to resident abuse, as identified within the home's abuse policy and within the Long-Term Care Homes Act, 2007, Ontario Regulations 79/10.

The plan is to be submitted to Saran.DanielDodd@ontario.ca by May 10, 2017 and implemented by June 30, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #026 was protected from abuse by anyone and not neglected by the licensee or staff.

During record review of resident #026 progress notes, the inspector reviewed multiple documented incidents of inappropriate behaviour by resident #027

directed towards resident #026 and two other identified residents during a specified period.

The inspector was not able to obtain any evidence from the home that they established whether resident #026 had the capacity to provide consent and whether consent was provided in any of the documented incidents.

The inspector interviewed RN #131 who witnessed the incidents that occurred on three separate dates. RN #131 reported that resident #026 is unaware of his/her actions and is not able to give consent due to severe cognitive impairment.

PSW #157 was interviewed regarding an incident that occurred on an identified date which he/she witnessed. PSW reported that resident #026 was not aware of the actions taken and unable to provide consent for the incident. PSW #157 also reported that they witnessed resident #026's inappropriate behaviour toward resident #027.

RN #158 who witnessed two separate incidents was interviewed. RN #158 reported that resident #026 is unaware of his/her actions and is not able to give consent due to severe cognitive impairment.

PSW #128 and PSW #156 were interviewed and they reported that they are aware of and witnessed resident #027's inappropriate behaviour toward resident #026.

Interviews with PSWs #128, #156, #157, RN #158, #131, and the DOC reported that the only strategies to manage resident #027's identified behaviour is to monitor and redirect the resident when the behaviour is witnessed. The licensee failed to protect resident #026, resident #033 and resident #034 despite a known pattern of an identified behaviour of resident #027. [s. 19. (1)]
(189)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 19th day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAN Daniel-Dodd

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