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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 29, 2018;	2018_587129_0001 (A2)	029183-17	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Lifecare Centre
99 Wayne Gretzky Parkway BRANTFORD ON N3S 6T6

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

Amended by PHYLLIS HILTZ-BONTJE (129) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension to the compliance due date to O.Reg 79/10,s. 9 (1) related to door security. The compliance due date has been extended to November 28, 2018.

Issued on this 29 day of May 2018 (A2)

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

Original report signed by the inspector.

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Amended by PHYLLIS HILTZ-BONTJE (129) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22 and 23, 2018.

The following additional inspections were completed concurrently with the RQI inspection:

Critical Incident System (CIS) #005756-16 related to responsive behaviours,

CIS #026614-16 related to responsive behaviours,

CIS #029985-16 related to responsive behaviours,

CIS #031281-16 related to responsive behaviours,

CIS #007478-17 related to abuse,

CIS #016194-17 related to safe, secure home,

CIS #017288-17 related to elopement and,

Complaint #023992-17 related to personal care issues.

CIS inspection log #028953-17 which was initiated prior to the RQI was also inspected during the course of the RQI. There will be a separate report generated for this CIS inspection identified as:CIS inspection #2017_555506_0028/028953-17. Non-compliance identified during the inspection that was similar to non-compliance issued during the RQI inspection will appear

in this RQI report. This included non-compliance related to Ontario Regulation 79/10, s. 15(1) - bed safety, O. Reg. 79/10, s. 107(1) 2 - reporting critical incidents and O. Reg. 79/10, s. 8(1) b - compliance with the licensee's policy.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Restorative Coach, the Resident Care Coordinator, the Physiotherapist, Dietary Aides, Family Council Chairperson, Family Council liaison, the Administrative Assistant, Recreation staff, housekeeping staff, maintenance staff, Resident Assessment Instrument-Minimum Data Set coordinator, Recreation Manager, Administrative support staff, Director of Nutrition and Support Services (Environmental), Chief Financial Officer, the Assistant Director of Care, the Director of Care and the Interim President.

During the course of this inspection the inspectors toured the home, observed resident care, reviewed clinical records, observed medication administration, reviewed training records, reviewed continent care product records and reviewed the licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

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

- **26 WN(s)**
- **13 VPC(s)**
- **6 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with prevailing practices to minimize risk to the resident.

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The clinical guidance document is cited in a document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008", and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

Nine residents (#001, #002, #003, #004, #006, #007, #008, #009, #060) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. A restorative coach, identified themselves as the person who completed many of the resident assessments, including several that were reviewed. The assessment was determined to be missing several procedures in identifying the risk over the benefits of bed rail use for residents using one or more bed rails.

a) The licensee's policy and procedure titled "Medical Beds and the Potential for Resident Entrapment (5-RS-35)" did not include any procedures related to how a

resident would be clinically assessed for bed related safety hazards while in bed with bed rails applied. The policy included direction that "each resident and bed system would be assessed to determine if the system that they are using is appropriate and safe for them" and that "residents are assessed on admission, change in condition or when their bed system was changed". The policy did not include who would be involved in the assessments, what form or tool would be used to collect appropriate information about the resident's condition, their risk factors for bed safety related hazards and ability to use bed rails safely or a reference to the above noted clinical guidance document for additional guidance. A memo dated November 18, 2016 addressed to "all staff" from the Director of Care included information that restorative coaches would complete a "Bed Entrapment Assessment" upon admission and that "bed rails will be removed as they are considered best practice due to risk for entrapment" and that families/residents had the option of either no bed rails or an assist bar for bed mobility.

b) The "Bed Entrapment Assessment" form included two sections. The first section included 10 questions requiring a "yes" or "no" answer related to the resident's cognition, size of head, evidence of involuntary movements, overall mobility, ability to get out of bed unsupervised and ability to use the bed remote. The conclusion included if bed rails would be used and if so, the type that would be applied. The second section included what zones of entrapment passed or failed on the resident's bed. Restorative Coach (RC) #102 reviewed several of the assessments with inspector #120 and #506 to determine what collaborative or interdisciplinary approach was taken when completing the assessments. The RC reported that they acquired the answers to some of the questions to complete the first section from an RN. The questions related to bed mobility, transfer abilities and use of bed remote were assessed by the RC. An interdisciplinary team was not developed to clinically assess each resident who was provided with any type of device on their beds, whether an assist bar, assist rail or bed rail (of any size). According to the clinical guidance document, the composition of the interdisciplinary team may vary depending upon the nature of the care and service setting and the resident's individual needs. Team members for consideration include, but are not limited to: nursing, social services, physicians (or their designees); rehabilitation and occupational therapists; patient; family (or authorized representative); and medical equipment suppliers. The RC #102 reported that PSWs, who spent a lot of time with the residents, were not involved in the assessments and registered staff were minimally involved by providing answers to some of the questions. The "Entrapment Assessments" completed for all of the residents reviewed included only one signature, that belonging to the RC.

c) Documentation for nine out of the nine residents that were reviewed did not include any information about the resident's sleep or night time habits, medical condition, pain, medication use, existence of delirium, continence patterns, behaviours, falls risk or communication abilities, as potential risk factors for increased bed related injuries, entrapment, suspension and entanglement where bed rails were applied. Some of these factors were identified in the written plan of care for each resident, but were not reviewed in relation to bed safety. A resident sleep observation process after bed rails were applied was not included in the overall resident assessment process. According to the clinical guidance document, each resident has differing sleep and night time habits and a period of time is required while the resident is in bed, if bed rails have been applied, that best identifies how residents interact with the bed rails during various stages of sleep.

The RC did not observe any of the eight residents in bed throughout the night to determine what safety hazards were identified, if any. The RC provided a document for review titled "General Device Guidelines" which was given to them by former management staff, who were no longer available in the home. The document included direction for the RC to assess residents visually on admission for "bed system modifications" such as "assist bars and bed rails" and to complete a bed entrapment evaluation only on those beds that had "full or partial bed rails". If the resident was provided with "assist bars", zones 1-4 (in and around the bed rail) were not evaluated for entrapment zones 1-4. The RC explained that they did not consider the "assist bars" located on many of their beds as "bed rails" because they were only 12 inches wide. The "General Device Guidelines" for the registered staff included the requirement to complete documentation that the resident provided consent for the use of the bed rails, that residents were monitored while the device (bed rail) was applied and whether an alternative was trialled. The documentation requirement was only required if the bed rail was either a restraint or limited or inhibited the resident from getting out of bed. Residents with an "assist bar" therefore were not included in any structured form of monitoring or assessment.

According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape". The definition of a bed rail is "an adjustable metal or rigid plastic bars that attaches to the bed, that are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths". Once bed rails are applied, residents would need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed

over a period of time to establish risk-related hazards associated with their bed rails. The risk-related hazards include but are not limited to strangling, suffocation, bruising or injury against the bed rail, suspension around a bed rail (if centrally located on the bed), entanglement and entrapment. The licensee's policy would need to establish who would monitor the residents, for how long and what specific hazards would need to be monitored while the resident was in bed with one or more bed rails applied for all of the previously mentioned hazards.

d) According to RC #102, the "Memo" dated November 18, 2016, included an attachment or fact sheet titled "Bed Systems and Safety", which was provided for review. It included information about entrapment deaths in Canada, the benefits and risks of bed rail use and what changes were being made in the home. The fact sheet included the following statements; "bed rails will be removed from bed systems, if they are not required" and "bed rails will be replaced with assist bars, which provide a device on the bed system that allows the resident something to hold on to, without the risk of entrapment". The licensee's understanding of the potential hazards associated with assist bars was not in accordance with the clinical guidance document.

e) Nine out of the nine clinical bed safety assessments that were completed within the last 12 months did not include what bed rail alternatives were trialled before the bed rails were applied. The "Entrapment Assessment" form did not include an area for the assessor to complete related to what alternatives were trialled, when they were applied, for how long and whether successful or not. The residents' clinical records (progress notes) were reviewed and did not include any reference to alternatives trialled. The licensee's bed safety policy did not reference or include any options such as transfer pole, bed rail guards or padding, height adjustable bed, raised perimeter mattress (easier to grab than a flat mattress when being repositioned) or adjustable bolsters (also known as soft rails). The licensee's bed safety policy did not include what strategies, accessories or options were available to staff and the resident if certain bed safety risks were identified such as suspension, bruising, entanglement or entrapment (for the various different zones).

f) Loose bed rails were noted on three resident beds, creating a condition that could increase the likelihood of bed related injury or entrapment for the resident. Depending on the type of bed rail attached to the frame, the frequency of use and the type of hardware used to attach the bed rails to the frame, loose connections can occur. The bed systems in the home consisted of five different types of bed rails. These included an assist bar (with easy pull knob release allowing rail to

rotate up or down), a quarter length plastic moulded "half-head" side rail which could be lowered up or down, a plastic moulded 3-position assist side rail which could be rotated 90 degrees (towards or away from the mattress), a quarter length "head rail" with three positions (low, normal guard and high) that could be lowered up or down and a metal assist rail (with easy pull knob release allowing bed rail to rotate 180 degrees into 3 different positions, guard, assist or transfer). The licensee however had identified the names of the bed rails as either half rails or assist bars.

Resident #006 was not in bed and it was noted the bed was equipped with two bed rails which were both elevated. The bed rail on the resident's right side was loose, creating a gap between the bed rail and the mattress (end of bed rail) large enough for the inspector #120's knee to fit into the space. The resident's plan of care included the need to apply both "half rails" for the resident to engage in activities of daily living. The RC and maintenance staff were unaware of the loose bed rail and stated that the staff did not report the issue.

Resident #060 had one rail on the bed on the specified side. The licensee identified the rail as an "assist bar". The resident's plan of care identified that the resident needed one assist bar to assist with positioning. The assist rail was constructed so that the bed rail could be attached or removed by pressing a release button on the side of the rail. The connections between the holder attached to the frame of the bed and the bed rail itself was loose, causing the assist rail to swivel away from the mattress, creating a minor gap large enough for an arm to slip between the mattress and the rail.

g) Resident #002 was in bed at the time of observation with both of their assist bed rails attached and in the guard position. The resident reported that they did not use the bed rails other than to grab on to them when staff completed care. Their written plan of care included that the resident had two half rails and seven other care focus areas that could impact on the resident's interaction with their bed system. The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). Bed related risk factors were present, as identified on the plan of care and partially on the "entrapment assessment", however they were not analyzed as part of the overall assessment. The resident was not assessed in accordance with prevailing practices as identified. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted. No risk over benefit conclusion

was made with respect to the application of the assist bed rails for this resident.

h) Resident #004 did not have an "entrapment assessment" completed and was admitted to the home in 2011. The resident was in bed when observed with both side rail elevated. Their written plan of care included that the resident was to have two bed rails applied when in bed to aid with positioning and seven other care focus areas that could impact the resident's interaction with their bed system. Bed related risk factors were present, as identified on the plan of care, however they were not analyzed as part of the overall assessment. The resident was not assessed in accordance with prevailing practices as identified. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted. No risk over benefit conclusion was made with respect to the application of the assist bed rails for this resident.

i) Resident #007 was in bed at the time of observation, with both of their rails in a transfer assist position. Staff #100 and #101 confirmed that they did not use the bed rails other than to grab on to them when staff completed care and this was not always the case it depended on the resident. Their written plan of care included that the resident had two rails to aid in positioning and five other care focus areas that could impact the resident's interaction with their bed system. The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

j) Resident #008 was in bed at time of observation, with both their rails in a transfer assist position. Staff #100 and #101 confirmed that the resident uses the rails to roll over and reposition themselves while in bed. Their written plan of care included that the resident had two rails to aid in positioning and help with activities of daily living care and three other care focus areas that could impact on the resident's interaction with their bed system.The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

k) Resident #009 used two assist bars in bed and at the time of the observation it was noted that both of their rails in a transfer assist position. Staff #100 and #101 confirmed that the resident uses the rails to roll over and reposition themselves while in bed and assist with transferring out of bed. Their written plan of care included that the resident had two rails to aid in positioning and help with activities of daily living care and six other care focus areas that could impact on the resident's interaction with their bed system. The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

l) Resident #001 used two assist bars in bed for transferring and positioning as confirmed through clinical record review. Staff #100 and #101 confirmed that the resident used the rails to roll over and reposition themselves while in bed and assist with transferring. Their written plan of care included that the resident had two rails and eight other care focus areas that could impact on the resident's interaction with their bed system.The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

m) Bed systems that included all bed rail styles with the exception of bed rails styles from two identified suppliers were not evaluated for entrapment zones 1-4. According to RC#102, all other bed rail styles were not considered to be “bed rails” when they were purchased and they did not receive any evaluations using a specialized tool designed to measure the fit and compression of mattresses in and around an attached device.

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. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.

Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91(1) of the Act:
Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. A local health integration network under section 19 of the Local Health System Integration Act, 2006 including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act".

The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies.

The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services

to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA."

Section 51(2) of the Regulation under the LTCHA identified the following:
"51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence."

If a resident was assessed to require a specific incontinent care product then it shall be provided as part of the range of continence care products to be provided at no charge by the home.

The licensee permitted a person to make a charge or accept a payment on the licensee's behalf for continence care products, for which they received funding from the local health integration network under the service accountability agreement.

a) Resident #016's current plan of care identified they required specific interventions related to continence care and used an identified continence care product. Clinical documentation confirmed that a care intervention initiated on an identified date, indicated the resident used an identified continence care product that was not provided by the licensee.

The most recent continence assessment indicated that the resident used the identified continence care product. The most recent Resident Assessment Instrument - Minimum Data Set (RAI-MDS) document confirmed that staff had reviewed the plan of care and the care interventions remained current.

During an interview PSW #119 indicated the resident experienced altered continence and the resident used an identified continence care product. PSW #119 indicated they had worked in the home for several years, and during that time the licensee had not provided the continence care product the resident #016 was assessed as requiring.
During an interview with the Director of Care (DOC) on January 16, 2018, they confirmed that based on the care needs identified for resident #016, the continence care product resident #016 used would have met their identified care needs.

Resident #016's plan of care indicated the resident required the use of a continence care product that the licensee did not provide and for which the licensee accepted payment.

b) Resident #031's current plan of care identified specific care interventions related to continence care and they used an identified continence care product. Clinical documentation confirmed that a care intervention initiated on an identified date, indicated the resident used an identified continence care product that the licensee did not provide.

The most recent continence assessment confirmed that the resident used a specific continence care product. The most recent RAI-MDS document confirmed the resident's care plan had been reviewed and the care interventions remained current.

During an interview PSW #121 indicated the resident experienced altered continence and used a specific continence care product. PSW #121 indicated they had worked in the home for several years and were not aware if the licensee provided the specific continence care product resident #031 was assessed to use.

During an interview with the DOC on January 16, 2018, they confirmed that based on the identified care needs of resident #031, the continence care product used by the resident would have meet the needs of this resident.

Resident #031's plan of care indicated that the resident required the use of a

specific continence care product that the licensee did not provided and for which the licensee accepted payment.

c) Resident #032's current plan of care identified specific care related to the assistance they required to use the toilet and that the resident used a specific continence care product. Clinical documentation confirmed that a care intervention initiated on an identified date, indicated the resident used the identified continence care product.

The most recent continence care assessment indicated the resident used the identified continence care product. The most recent RAI-MDS document confirmed that the care plan had been reviewed and care interventions remained current.

During an interview with PSW #122, they explained that the resident used the specific continence care product. PSW #122 confirmed that they had worked in the home for several years and the home did not provide the continence care product resident #032 had been assessed to use.

During an interview with the DOC on January 16, 2018, they confirmed that based on the identified care needs of resident #032 the continence care product the resident used would have meet the needs of this resident.

Resident #032's plan of care indicated the resident was assessed as requiring the identified continence care product that the licensee did not provide and for which the licensee accepted payment.

d) A random tour of four resident home areas continence care product storage rooms, confirmed that there were no licensee provided continence care products of a specific style. This information was confirmed at the time of the tours by PSW #127, PSW #128, PSW #122, PSW # 129 and PSW #130.

e) During the course of this inspection RPN #117, PSW #116, PSW #119, PSW #121, PSW #122, PSW #127, PSW #128, PSW #129 and PSW #130 confirmed that they were either unaware if the licensee provided the continence care products resident #016, resident #031 and resident #032 used.

Additional Required Actions:

(A1)(Appeal/Dir# DR# 081)
The following order(s) have been rescinded:CO# 002

WN #3: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an

emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

2. The licensee did not ensure that the following rules were complied with:

All doors leading to stairways and the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. connected to the resident-staff communication and response system.

The long term care home was equipped with three stairwell doors located in each of the 8 home areas. Other doors to which residents had access and lead directly to insecure outdoor areas included the main entrance door. Each door was equipped with a door access control device, which included a key pad next to each door and magnets on the door and frame. The doors remained locked until a code was entered on the key pad to release the magnets. Random doors and the main entrance door were selected to test the door access control system. Stairwell doors labelled 2-3, 9-3, 1-3, 8-3, 3-3, 2-2, 2-1 and the main entrance door were held open for two minutes once they were unlocked. After two minutes, no audible door alarm sounded at the doors.

The long term care home's resident-staff communication and response system was equipped with activation stations (in each resident accessible area), a visual component in the form of dome lights and an audio component, which included portable phones carried by health care aides. When an activation station was activated, the phones alerted staff to the location of the call. All stairwell doors and the main entrance door were required to be connected to this system. However, the main entrance door and the above noted stairwell doors that were tested were not connected to the resident-staff communication and response system. The doors were tested by holding the doors open for two minutes and waiting for the portable phones carried by health care aides to sound. The doors were confirmed to be unlinked to the resident-staff communication and response system. The registered staff and health care aides who were in the home areas at the time of testing, stated that their portable phones did not alert them to any open doors. The registered staff were unaware that stairwell doors should have alarmed if they did not close properly or were held open for too long. A maintenance person who was very familiar with the various building systems stated that they were unaware that the stairwell doors and the main entrance door were required to be connected to

the resident-staff communication and response system and did not test the system themselves to ensure that it was functional.

The licensee did not ensure that the following rule was complied with:

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

A specified activity room balcony door was equipped with a slide lock, but the lock was not engaged to restrict unsupervised access to the balcony by residents on two identified dates in January 2018. The RN who was on duty was unaware of the unlocked balcony door and was asked if they had the key to lock it. The RN was subsequently observed locking the balcony door.

A specified activity room balcony door was equipped with a slide lock, but the lock was not engaged to restrict unsupervised access to the balcony by residents in January 2018. The RN who was on duty, was unaware of the unlocked balcony door and was asked if they had the key to lock it. The RN could not find a key and directed a staff member to monitor the door while they tried to get assistance in finding the key.

The registered staff were each asked if it was part of their routine to check the balcony doors to ensure they remained unrestricted when unsupervised. Several of the registered staff reported that it was not a task that they conducted.

The long term care (LTC) home included non-residential areas consisting of medical and non-medical related offices on the fourth floor that were accessible to the public from the ground floor. The fourth floor, which was designated for long term care staff offices, was segregated by a door which led to the medical and non medical offices or public area. The public area also consisted of one passenger elevator (also included access to the fifth floor, a non LTC area). One of the offices was advertised being open on the weekends. The public was observed using the elevator on two identified dates, to access these offices and a medical clinic located in the LTC home corridor. The door that segregated the LTC home side from the public side was equipped with a magnetic locking system and a key pad next to the door. During the inspection the door was not supervised by any staff and was not locked to restrict unsupervised access to the public area by residents on two identified dates. Two elevators located on the LTC home side were easily

accessible to residents that resided on three other floors. However, if a resident exited the elevators on the fourth floor, they required a code to get back onto the elevator. If the resident did not know the code, they could not get back down to their floor without staff assistance. Once on the fourth floor, the resident would have easily been able to use the public elevator and get down to the ground floor and outside of the home or to the fifth floor. Staff member #139 reported that they had seen residents on the fourth floor numerous times in the past, especially on weekends when LTC staff were not available to re-direct them back to their home areas.

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimeters (cm).

Certain areas of the long term care home were equipped with single hung windows that were designed to slide open vertically, with double panes. They were located in resident bed rooms, dining rooms and lounge areas on each home area. These windows were observed to be missing a device to restrict the windows from being opened more than 15 cm. On January 4, 2018, an interior pane window was observed to be open more than 20 cm in a lounge on a specified home area. Neither of the two panes had a restriction device in place. Subsequently, a random number of windows were selected for review. The widows were missing a restriction device in the additional areas. The observations were reported to the Manger of Programs and Support Services, who was unaware of the issue. The manager was informed that the number of windows without the device may include additional windows and that a home wide check would identify any missed during the random inspection completed. On January 16, 2018, windows located in several areas were found unrestricted.The observations were reported to a maintenance person for follow up. The maintenance person reported that checks or audits to ensure windows did not open more than 15 cm were not done by staff in the home.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Resident #044's clinical record indicated they had three diagnoses related to cognitive function and resident #043's clinical record indicated they also had a diagnosis related to cognitive function. On an identified date in 2016 resident #044 engaged in an altercation with resident #043. This altercation resulted in resident #044 sustaining an injury.

A few days following the above noted altercation resident #044 and resident #043 were again involved in an altercation that resulting in resident #043 receiving an injury that required transfer to and treatment in hospital.

Interview with registered staff #132 and the Assistant Director of Care (ADOC) on January 17, 2018, confirmed that steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information that could potentially trigger such altercations. It was confirmed that no responsive behaviour assessments were completed after the incident between resident #044 and #043 for which resident #043 was transferred to hospital and not all potential triggers to altercations had been identified. [s. 54. (a)]

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

a) Resident #025's clinical record indicated they demonstrated responsive behaviours towards co-residents. In 2017, two days apart, resident #025 engaged in altercations with resident #042 and resident #010. These altercations resulted in superficial injuries to both residents. A review of the care plan in place for resident #025 at the time of the above noted altercations did not include interventions to prevent altercations with co-residents. After the two incidents the home did not identify nor implement any new interventions to minimize risks of altercations among residents. An interview with the Resident Care Coordinator (RCC) confirmed at the time of the incidents the home did not take steps to minimize the risk of altercations and potentially harmful interactions between and among residents. (506)

b) Resident #042's clinical record indicated they demonstrated responsive behaviours towards co-residents. Resident #042's clinical record confirmed that the resident engaged in altercations with co-residents on more than one occasion. The plan of care in place at the time of these altercations did not include interventions to prevent altercations with co-residents. The home did not identify nor implement any new interventions to minimize risks of altercations among residents. An interview with the RCC confirmed at the time of the incident the home did not take steps to minimize the risk of altercations and potentially harmful interactions between and among residents. (506)

c) Resident #044's clinical record indicated they had diagnoses related to cognitive function. On an identified date in 2016 resident #044 had an altercation with resident #043 during which resident #044 sustained an injury. A few days following the identified incident resident #044 and resident #043 were again involved in an altercation that resulted in resident #043 sustaining an injury that required treatment in hospital.
Interview with registered staff #132 and ADOC on January 17, 2018, confirmed that steps were not taken to minimize the risk of altercation and harmful interaction between resident #044 and #043 following the above noted incident and that no new intervention were identified or implemented after the altercation following which resident #043 was transferred to hospital. (156)

d) Resident #045's clinical record indicated the resident demonstrated responsive behaviours towards co-residents. On an identified date in 2016, resident #045 and resident #047 engaged in an altercation. This altercation resulting in resident #047 sustaining an injury. Earlier that day, resident #047 was in an altercation with resident #033 which resulted in an injury. Interview with registered staff #106 on January 23, 2018, confirmed that steps were not taken to minimize the risk of altercation and harmful interaction between resident #045 and #047 and that no new interventions were identified or implemented to prevent the interaction of these two residents following the above noted altercations.

On an identified date resident #045 engaged in an altercation with resident #032 which resulted in injury to resident #032. Interview with registered staff #106 on January 23, 2018, confirmed that steps were not taken to minimize the risk of altercation and harmful interaction between resident #045 and #032 and that no new interventions were identified or implemented to prevent the interaction of the two residents following the above noted incidents.

(Please note: The non-compliance identified above related to resident interactions was identified during an inspection of CIS 031281-16 and CIS #026614-16) (156) [s. 54. (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 and ensuring steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) The licensee failed to protect resident #035 from sexual abuse by co-resident #034.

In accordance with O. Reg. 79/10, s. 2(1) sexual abuse is defined as, "any non-consensual touching, behaviours or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Clinical documentation and a Critical Incident Report (CIR), submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated resident #035 was abused by co-resident #034.
Personal Support Worker (PSW) #133 confirmed that resident #035 demonstrated what they believed to be a limited understanding of issues occurring around them.
Registered Practical Nurse (RPN) #138 confirmed that they believed resident #035 would not have been able to consent due to a cognitive impairment. RPN #138 confirmed that co-resident #034 understood their actions.

PSW #133 and a written statement they provided to the Director of Care (DOC) at the time of the incident, confirmed that on and identified date in 2017, they observed the co-resident move themselves up to resident #035. PSW #133 indicated in the statement that the co-resident placed themselves in a position which prevented resident #035 from removing themselves from the situation. The co-resident was then observed by PSW #133 to speak to resident #035. PSW #133 immediately intervened to remove the co-resident from the area and reported this incident to their supervisor.
The licensee failed to protect resident #035 from abuse.

a) The licensee failed in their duty to protect resident #035 from abuse when identified behaviours of the co-resident were not assessed and care interventions were not put in place to manage those behaviours.
During an interview on January 19, 2018, RN #134 was asked if they had been made aware of staff's concern about unusual behaviour that had been demonstrated by the co-resident towards co-residents and they responded "we were watching the co-resident because we felt we had to". RN #134 was unable to identify specifically why they thought they felt they had to watch the co-resident.

Prior to the above noted incident, clinical documentation made by registered staff in the co-resident's clinical record indicated that the resident had been seen to place themselves in front of another co-resident. The co-resident became agitated with this behaviour and attempted to walk away from the co-resident, the co-resident then continued to follow the other co-resident around the home area.
During an interview on January 19, 2018, RPN #135 stated that the day prior to the incident noted above, "there was some inclination that there were some behaviour problem" with the co-resident and they "had a weird feeling" about the co-resident. RPN #135 confirmed that they were in the vicinity of when the above noted incident occurred.
PSW #133, who observed the incident, submitted a written statement to the DOC. In the statement PSW #133 indicated that they had been aware for a few days prior to the incident that the co-resident had been following resident #035 around two home areas. During an interview conducted via telephone on January 19, 2018, PSW #133 confirmed their concern about the co-resident's behaviour and that they were aware staff had been watching the co-resident due to their concern for other co-residents. The information provided by PSW #133 during the interview was consistent with the written statement they had provided to the DOC at the time of the incident.
Although clinical documentation indicated that staff communicated to an official

who attended the home following the incident, that the doors had been closed to limit residents from going to the common elevator area for the time being, that they would consider moving the co-resident to another floor if there were any signs of distress by resident #035 and that they would monitor the co-resident for a possible infection, there were no care interventions placed in either the co-resident's or resident 035's plan of care related to the above noted actions. Documentation in the clinical record indicated that during the evening of the following day, there was another interaction between resident #035 and the co-resident when as resident #035 walked by the co-resident's room a staff member overheard the co-resident attempting to have resident #035 enter into their room.
RN #134, RPN #135 and clinical documentation confirmed that the behaviours the co-resident had been reported to demonstrate had not been assessed and the co-resident's plan of care had not been reviewed or revised in order to manage those behaviours and protect co-residents either before the incident noted above, or after this incident was reported and investigated.

b) The licensee failed in their duty to protect resident #035 from abuse when they failed to ensure that all staff received the mandatory training related to the prevention of abuse and neglect in the 2017 calendar year. Training records provided by the DOC confirmed that 28% of all staff had not received the required training.

c) The licensee failed in their duty to protect resident #035 from sexual abuse when they failed to ensure that the written policy to promote zero tolerance of abuse and neglect clearly identified what constituted abuse. The licensee's policy "Resident Abuse", identified as 1-NR-161, last revised on August 18, 2017 did not provide any direction related to what constituted sexual abuse and did not identify what constituted emotional abuse, financial abuse, physical abuse or verbal abuse as defined in O. Reg 79/10, s. 2(1).

3. The Licensee failed to protect resident #032, #043, and #047 and from abuse by co-residents #044 and #045.

In accordance with Ontario Regulation 79/10, s. 2 (1) physical abuse is defined as "the use of physical force by a resident that causes injury to another resident".

1. On an identified date in 2016, resident #044 had an altercation with resident #043. As a result of this altercation resident #044 sustained an injury. A few days

later, resident #044 and resident #043 engaged in an altercation. As a result of this second altercation resident #043 sustained an injury that required transfer and treatment in the hospital.
As per interview with the Assistant Director of Care (ADOC) on January 17, 2018, staff were aware that resident #044 posed a risk to residents and had previous altercations with co-residents. The licensee failed to ensure that the resident was protected from abuse when resident #043 was injured as a result of an altercation with resident #044.

2. On an identified date in 2016, resident #045 was involved in an altercation with resident #047. As a result of this altercation resident #047 sustained an injury. As per interview with the registered staff #106 on January 23, 2018, staff were aware that resident #045 posed a risk to residents and had previous altercations with co-residents. The licensee failed to ensure that the resident was protected from abuse when resident #047 was injured as a result of an altercation with resident #045.

3. On an identified date in 2016, resident #045 as involved in an altercation with resident #032. As a result of this altercation resident #032 sustained injuries. As per interview with registered staff #106 on January 23, 2018, staff were aware that resident #045 posed a risk to residents and had previous altercations with co-residents. The licensee failed to ensure that the resident was protected from abuse when resident #032 was injured as a result of an altercation with resident #045.

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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

s. 6. (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 failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

The plan of care for resident #012 included a number of care interventions related to nutritional care. During an interview, PSW #107 reported that the care they provided to the resident differed from the plan of care in relation to the amount of assistance the resident required at meal times, and the resident's diet. Registered staff #109 reported that the resident's had a medical incident months ago and was temporarily on a diet that was different than the plan of care and different than the diet PSW #107 identified the resident consumed. As confirmed with registered staff #109, the plan of care did not set out clear directions to staff and others who provided direct care to the resident in relation to their diet. [s. 6. (1) (c)]

2. 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.
Resident #053 had been assessed by the Registered Dietitian (RD), for an alteration in weight. The RD placed the resident on a specific diet and revised the resident's plan of care to include the change to the resident's diet.
On January 17, 2018, during an observation of the resident's lunch meal it was noted that PSW #119 provided the resident with a meal that was not consistent with the diet the RD had entered into the resident's plan of care. The meal was immediately removed from the resident's table and was substituted with a meal that was consistent with the diet identified in the resident's plan of care
During an interview, PSW #119 indicated they were unaware that the resident's diet had recently changed. PSW #119 stated the meal had been plated by Dietary aide (DA) #131.
The Inspector went to the meal servery and asked the DA to check the diet order on the diet sheet available at the servery. The DA stated the dietary sheet indicated the resident was to receive the same diet ordered by the RD, but had plated a meal that was inconsistent with the diet identified in the resident's plan of care. Interview with RPN #124 confirmed the resident was to receive the diet type specified in the plan of care. Resident #053's care had not been provided as per their plan of care when the DA #131 had plated a meal and the PSW provided a meal to resident #053 that was inconsistent with the diet directions in the resident's plan of care. [s. 6. (7)]

3. The licensee 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 changed or care set out in the plan was no longer necessary.

a) Resident #025 had 16 documented incidents of responsive behaviours over a three month period of time in 2016. The plan of care in place at that time, did not include a focus statement for the types of responsive behaviours demonstrated by the resident towards co-residents nor any interventions to prevent responsive behaviours towards co-residents. The Resident Care Coordinator (RCC) confirmed on January 18, 2018, that the plan of care had not been revised when the resident's care needs changed related to increase in responsive behaviours toward co-residents. (506)

b) Resident #042 had 10 documented incidents of responsive behaviours over a three month period of time in 2016. The plan of care in place at this time, did not include a focus statement for the responsive behaviours demonstrated by resident

#042 towards co-residents nor any interventions to prevent responsive behaviours toward co-residents. The RCC confirmed on January 18, 2018, that the plan of care had not been revised when the resident's care needs changed related to increase in responsive behaviours towards co-residents. (506)

c) During an interview on January 15, 2018, PSW #119 revealed that resident #016's condition and care requirements had changed in relation to continence care, ambulation and the resident's cognitive function. An interview with Registered Practical Nurse (RPN) #117 and a review of clinical documentation confirmed that at the time of this inspection resident #016's plan of care did not reflect the resident's change in condition and care requirements identified by PSW #119. RPN #117 confirmed that the resident's condition had changed as identified by PSW #119 related to continence care, ambulation and the resident's cognitive function and these changes had been in place for some time. During an interview RPN #117 reviewed care interventions contained in resident #016's plan of care and confirmed that the care interventions had not been reviewed or revised related to continence care, ambulation or cognitive functioning, when the resident's care needs had changed in these care areas and acknowledged that care interventions should have been altered to reflect the current needs of the resident. (129)

d) Resident #034's plan of care was not reviewed or revised when staff who provided care to the resident and clinical documentation indicated that resident #034's behaviour had changed. Clinical documentation and a Critical Incident Report (CIR), submitted to the Ministry of Health and Long Term Care in 2017, confirmed that resident #034 demonstrated an identified responsive behaviour toward a co-resident. Following the above noted incident Behavioural Support Ontario (BSO) saw resident #034 and made a recommendations for the management of the responsive behaviour demonstrated by the resident. RPN #138 and clinical documentation confirmed that resident #034's plan of care had not been reviewed or revised following the above noted incident and the plan of care did not contain behavioural interventions related to the management of the identified responsive behavior.

(PLEASE NOTE: The above noted non-compliance related to the review and revision of the plan of care for resident #034 was identified while inspecting Critical Incident Report inspection log # 007478-17.) [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the plan of care had not been effective.

a) Resident #010's plan of care was not reviewed and revised when the care set out in the resident's plan of care had not been effective in relation to the identified falls care focus. Clinical documentation confirmed the resident experienced a fall on an identified date in 2017, and a second fall on an identified date in 2018. Registered Practical Nurse (RPN) #106 and clinical documentation confirmed that the goal of care related to the risk of falls established by the care team was that the resident would have no falls through the next 90 days. This care goal was initiated in 2015, with a target date of March 1, 2018. RPN #106 and clinical documentation confirmed that the resident's plan of care was not reviewed or revised when the care provided was not effective in attaining the care goal and there were no additional care interventions implemented following either of the above noted falls in order to attempt to decrease the risk of recurring falls for resident #010. (129)

b) The care plan in effect for resident #011, confirmed that the resident was a risk for falls and a current goal was that the resident would have no falls through the next 90 days. Care interventions were included in the resident's plan of care to manage the risk of falling.
Resident #011 sustained an unwitnessed fall on an identified date in 2017, with no injury and sustained a second unwitnessed fall, without injury, 44 days later.
A clinical record review confirmed that the care plan had not been revised when the care set out in the plan had not been effective and the goal was not met after each fall. In an interview with the ADOC on January 9, 2018, they confirmed that it is the registered staff's responsibility to review and revise the residents' plan of care after each fall incident when completing the post fall assessment. The plan of care was not revised when the care in the plan was not effective in mitigating the resident's risk of falls. (506) [s. 6. (10) (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 and ensuring care set out in the plan of care provided clear direction to staff who provide care, was provided to the resident as specified in the plan, residents are reassessed and the plan of care reviewed and revised when the resident's care needs changed and care set out in the plan was no longer necessary or the plan of care had not been effective, to be implemented voluntarily.

WN #8: 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 :

The Licensee failed to ensure that 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, was complied with.

1. In accordance with Long Term Care Homes Act, 2007, c. 8, s.8 (1) and O. Reg 79/10, s. 30(1) the licensee is required to have a program of Nursing and Personal Support Services includes policies and procedures.
a) The licensee had a policy in place in the Nursing Manual titled "Coroners Investigation", last revised August 30, 2017, that directed; in the event of an

unexpected death as the result of an accident, suicide, homicide and undetermined cause, the Registered Nurse will contact the resident's physician and the body will not be touched or moved until the examination by physician.

On an identified date in 2017, RPN #114 was called to assess resident #001. The RPN felt for a carotid pulse and there was none and then called RN #115 to assess the resident. The RN then proceeded to move the resident prior to the physician coming to assess the resident. In an interview with RN #115 confirmed that they chose to move the resident. In an interview with the DOC on January 11, 2018, confirmed that the home's policy was not complied with.
(Please note: This finding of non-compliance related to compliance with the licensee's policy "Coroners Investigation" was identified during Critical Incident Inspection 2976-000016-17) (506)

b) The licensee had a policy in place in the Nursing Manual titled "Responsive Behaviours Risk Management" (last revised 01/11/16) that stated, after each incident that an interdisciplinary analysis of each incident should be carried out to serve the purpose of prevention in the future and the analysis should include areas such as:
a. Resident-staff interaction
b. Resident-resident interaction
c. Resident-environment interaction
d. Resident-family-staff interaction.
i) A clinical record review for resident #025 confirmed that the resident displayed physical responsive behaviours. On two occasions over one month in 2016, that resulted in superficial injury to two co-residents. In an interview with the ADOC on January 17, 2018, the LTC Homes Inspector asked where to find the documentation that an interdisciplinary analysis took place after both ofthe incidents. The ADOC produced minutes from the Responsive Behaviour and Antipsychotic Reduction Meetings that were held following the two above mentioned incidents and the ADOC confirmed that if an incident took place it would be documented on these monthly meeting minutes. A review of the meeting minutes confirmed that the resident and the responsive incidents were not mentioned or discussed and this was confirmed with the ADOC on January 17, 2018, and they confirmed that the policy was not complied with. (506)

ii) On an identified date in 2016, resident #044 had an altercation with resident #043. This altercation resulted in resident #044 sustaining an injury. A few days later, resident #044 engaged in another altercation with resident #043, which

resulted in resident #043 sustaining an injury that required transfer and treatment in the hospital. In an interview with the RCC on January 23, 2018, Responsive Behaviour and Antipsychotic Reduction Meeting minutes were reviewed and confirmed that the resident and the responsive incidents were not mentioned or discussed as per the home's policy. It was confirmed that the policy was not complied with. (156)

iii) On an identified date in 2016, resident #045 engaged in an altercation with resident #047, which resulted in resident #047 sustaining an injury. Earlier that day, resident #047 was in an altercation with resident #033, which resulted in resident #033 sustaining an injury. In an interview with the RCC on January 23, 2018, Responsive Behaviour and Antipsychotic Reduction Meeting minutes were reviewed and confirmed that the resident and the responsive incidents were not mentioned or discussed as per the home's policy. It was confirmed that the policy was not complied with. (156)

iv) On an identified date in 2016, resident #045 engaged in an altercation with resident #032, which resulted in resident #032 sustaining injuries. In an interview with the RCC on January 23, 2018, Responsive Behaviour and Antipsychotic Reduction Meeting minutes were reviewed and confirmed that the resident and the responsive incidents were not mentioned or discussed as per the home's policy. It was confirmed that the policy was not complied with. (156)

c) The home's Respiratory Care Policy 1-NR-173, located in the Nursing Manual was reviewed as provided by the RCC. The policy stated the Department of Nursing would adhere to the policies outlined in an identified contract service provider's Manual
The policies and procedures included, but was not limited to, the following directions:
a) Registered Nurses or Registered Practical Nurse must receive training related to an identified respiratory therapy prior to becoming responsible for the care of residents receiving the therapy.
b) A written nursing care plan must be developed to include the specific therapy.
c) Documentation and charting by Home staff should be consistent (e.g. time of administration, effect of the therapy, vital signs, the resident's general condition, etc.).

Resident #053's clinical record indicated the resident had a respiratory medical diagnosis.

i) Registered Nurses or Registered Practical Nurse must receive training in the use of a respiratory therapy prior to becoming responsible for the care of residents receiving the therapy:
Interview with the RCC stated that an identified contracted company provided education to staff but was unable to confirm if all staff received training related to the therapy prior to becoming responsible for the care of resident #053 who received the therapy. A call was placed to the identified contact service provider where it was confirmed by a manager that CPR recertification training was provided on two identified dates in 2017, but could not confirm training was provided as outlined in the contracted service provider policy noted above. The manager indicated the home had access to an on-line training module that would print out a certificate of staff who chose to go online to complete each of the respiratory therapy training modules as outlined in the policy. The contracted service provider stated they did not track or follow-up to ensure all staff were trained as per the policy. The manager confirmed this would be completed and tracked at the home.
Interview with the DOC confirmed they were unable to confirm if all staff received training in relation to the identified therapy prior to becoming responsible for the care of resident #053 who received the therapy. The DOC confirmed there was no documentation or certificates to identify staff completed the on-line training.
ii) A written nursing care plan must be developed to include the specifics of the identified respiratory therapy.
A review of the clinical record had not identified a written care plan that included the specifics the identified therapy as provided and outlined in the "Guide To Respiratory Therapy Services for a Long term Care Facility" as outlined in the policy.
Documentation and charting by Home staff should be consistent with that of any therapy (e.g. time of administration, effect of the therapy, vital signs, the resident's general condition, etc.).
On an identified date in 2016, the home's physician documented resident #052 experienced a change in condition. Interview with the RCC confirmed they completed an investigation into the therapy treatment provided to resident #053 and had been unable to provide specific details of how the identified therapy was provided to the resident prior to the change in the resident's condition.
After a review of the clinical record by the RCC, they confirmed the home's registered staff had not documented in the Medication Administration Record (MAR) specific information required related to the therapy consistent with the physicians orders for the therapy. The MAR contained check marks only and had not identified the specific information required related to the identified therapy.

Interview with the RCC confirmed the registered staff had not completed documentation and charting related to the identified therapy consistent with the home's Respiratory Care Policy. (511)

3. In accordance with O. Reg. 79/10, s. 49(1) and 30(1)1 the licensee is required to have a Falls Prevention and Management Program that includes relevant policies, procedures and protocols.

The licensee's "Elder Care Fall Prevention and Management" policy and procedure, identified as # 1-NR-70 and last revised on July 31, 2017, directed that; "Registered Nursing staff are to monitor and evaluate the care plan at least quarterly in collaborations with the interdisciplinary team and if interventions have not been effective in reducing falls, initiate alternative approaches and update as necessary".
Staff did not comply with this direction when,
i) RPN #106 and clinical documentation confirmed that interventions had not been effective in reducing falls for resident #010. The current goal of care established on an identified date in 2015, indicated the resident would have no falls through the next 90 days. Clinical documentation indicated that resident #010 experienced a fall in 2017 and a fall in 2018.
RPN #106 and clinical documentation confirmed that this policy was not complied with when no alternative approaches were initiated after the above noted falls in order to reduce the risk of recurring falls for resident #010. (129)

ii) The ADOC and clinical documentation confirmed that interventions had not been effective in reducing falls for resident #011. The current goal of care established on an identified date in 2014, for the resident indicated that the resident would have no falls through the next 90 days. Clinical documentation indicated that resident #011 experienced two falls, over a 43 day period of time in 2017.
ADOC #011 and clinical documentation confirmed on January 10, 2018, that this policy was not complied with when no alternative approaches were initiated after the above noted falls in order to reduce the risk of recurring falls for resident #011. (506)

4. In accordance with O. Reg, 79/10, s. 48 (1) 3 and 30 (1) 1 the licensee is required to have a continence care and bowel management program that includes relevant policies, procedures and protocols.

The licensee's policy "Continence Care –Bladder and Bowel Management",

identified as I-NR-55 and last revised on January 3, 2017 directed:
a) "Continence products will be provide to all residents' who require them, at no charge to the resident based on assessed needs and fit."
The licensee failed to comply with the above noted direction when it was identified that resident #016, resident #031 and resident #032 used a continence care product that was not provided by the licensee. Resident #016, resident #031 and resident #032 had been identified on continence assessments as using an identified continence care product, had interventions in their plans of care that directed staff that the above noted residents used the identified product and it was confirmed by the DOC that the above mentioned residents abilities and care needs would be consistent with the identified product they used. (129)

b) "PSW's will document all specified continence issues as per policy on two identified documents and report unusual occurrences to the registered staff."
A review of resident #053's plan of care indicated the resident experienced altered continence. A review of documentation for the resident, completed by PSW care providers, indicated no documentation was made for 44 days over a two month period of time in 2017.
Interview with the ADOC confirmed the PSW's were to document in the identified documents as per the licensee's policy. The ADOC confirmed the home's Continence Care-Bladder and Bowel Management was not complied with when during the identified dates in September and October were not documented. (511)

5. In accordance with O. Reg, 79/10, s. 100, every licensee of a long term home shall ensure written procedures required under section 21 of the Act incorporate the requirements set out in section 101.
A review of the home's Complaints policy effective January 1, 2017 and last revised January 10, 2016, identified that it was the responsibility of the person receiving a written complaints/concern to document the information on a Concerns and Complaint form.
An interview with the DOC confirmed the home had received several written complaints. The DOC provided the Inspector with a copy of the written response addressed to the MOHLTC that they provided to a complainant on one identified date. The DOC was unable to provide a copy of the home's Concerns and Complaints form as identified in their policy. The DOC confirmed the licensee had not complied with their Complaints policy. (511)

6. In accordance with O. Reg, 79/10, s. 230 (4) the licensee shall ensure that there was a specified emergency plan.

A review of the home's emergency plans included a policy that was effective on May 1, 2018 and last reviewed September 1, 2015 that provided directions to staff.
Resident #054's clinical record confirmed that the resident demonstrated an identified responsive behaviour.
Interview with the DOC confirmed the home's policy was not complied with when the Director of Care/RN or designate failed to complete a debriefing report following an incident when resident #054 demonstrated an identified responsive behaviour.
(Please note: The above noted non-compliance related to the licensee's emergency plan was identified while inspecting Critical Incident System #017288-17) (511) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that staff comply with the licensees policies and procedures, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy "Resident Abuse", identified as 1-NR-161, last revised on August 18, 2017, directed: "Annual education will be held assisting all employees in further understanding resident abuse issues".
The licensee failed to ensure this direction was complied with when training records provided by the home and the Director of Care confirmed that 28% of all staff had not received training in the prevention of resident abuse and neglect in the 2017 calendar year.

(PLEASE NOTE: The above noted non-compliance related to complying with the licensee's policy, was identified while inspecting Critical Incident Report inspection log # 007478-17.) [s. 20. (1)]

2. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents that at a minimum complied with any requirement respecting the matters provided for in clauses (a) to (f) that are provided for in the regulations.

The licensee failed to ensure that the policy clearly set out what constitutes abuse in accordance with O. Reg. 79/10, s. 2(1).

The licensee's policy "Resident Abuse", identified as 1-NR-161, last revised on August 18, 2017, did not provide, at a minimum, a definition of what constitutes emotional abuse, financial abuse, physical abuse or verbal abuse as defined in O. Reg 79/10, s. 2(1). The Director of Care confirmed the descriptions of abuse included in the policy were not consistent with the definitions of what constitutes abuse as identified in the regulation. The Director of Care and the licensee's policy confirmed that the above noted policy did not address sexual abuse and did not set out what constituted sexual abuse between a staff member and a resident or a resident and a co-resident in accordance with O. Reg 79/10, s. 2(1).

(PLEASE NOTE: The above noted non-compliance related to the licensee's policy to promote zero tolerance of abuse and neglect, was identified while inspecting Critical Incident Report inspection log # 007478-17.) [s. 20. (2) (g)]

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 and ensuring the licensee's policy to promote zero tolerance of abuse and neglect of residents is complied with and that the licensee's policy clearly sets out what constitutes abuse, to be implemented voluntarily.

WN #10: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: 19. Safety risks.
Resident #054 was admitted in 2017, with a diagnosis. A review of the resident's Community Care Access Centre (CCAC) admission documents included a history of a previous behaviour demonstrated in 2017.
On admission, to the long term care home, the Resident Assessment Protocol (RAP) documented resident #054's Cognitive Performance Scale and that they required a level of action from staff for aspects of their activity of daily living (ADL) routine. The resident was at a risk for falls related to their behaviour. Resident #054 was further described to demonstrate a behaviour and encouraged to attend activity programs.
A review of the resident's Behavioural Minimum Data Set (MDS) assessment,

completed on admission documented the resident's identified behaviour occurred one to three days in the last seven day observation period and the behaviour was not easily altered. The next quarterly Behavioural MDS assessment, documented in 2017, documented the resident's identified behaviour increased to four to six days in last seven days and the behaviour remained not easily altered.
A review of resident #054's progress notes identified that on a specific date in July 2017, the resident was demonstrating a behaviour and an activity. Then on another day in July 2017, the resident was documented to be demonstrating the behaviour since a specific period of time. Intervention was provided with little effect. The resident was observed demonstrating the behaviour, with additional activities, settled briefly for a meal and then the behaviour started again. On another day in July 2017, the resident attended a program with staff.
A review of Critical Incident System (CIS) report described that on the date of the program, the resident, while unsupervised, demonstrated a behaviour and activity. The resident was observed to have fallen approximately one hour later, in a location and was taken to the hospital where they were diagnosed with an injury. The hospital contacted the resident's decision maker. The Resident Care Coordinator (RCC) confirmed the home had not been aware that the resident had demonstrated the behaviour, on the specific date, until they were notified by the resident's decision maker.
A review of the resident's admission plan of care identified the resident demonstrated a behaviour related to their status but had not identified an associated safety risk. Interventions for the behaviour were included in the plan; however, did not include during specific situations. Interview with RPN #141, Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coordinator, who had completed the admission MDS assessment stated that the resident had not been assessed on admission for the specific safety risk as noted on the CCAC admission documents. RPN #141 further stated the resident was not assessed for the specific risk on the MDS assessment, when the resident's specific behaviours increased. Interview with the RCC confirmed the resident was not assessed for their specific risk when the staff further identified in two progress notes dated in July 2017, that the behaviour included additional actions.
Interview with the RCC confirmed the plan of care had not included an interdisciplinary assessment with respect to the resident's specific safety risk. [s. 26. (3) 19.]

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 and ensuring plan of care is based on, at a minimum, an interdisciplinary assessment of safety risks, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to keep a written record related to each evaluation in accordance with O. Reg. 79/10, s. 30(1)3 that included the dates changes identified in the evaluation were implemented.

The Director of Care (DOC) provided the most recent annual program evaluations for the Falls Prevention program, the Continence Care program and the Restraint program. The DOC and the documents provided confirmed that as a result of these program evaluations staff identified action plans in order to improve the quality of

the care and services to the residents, however, the dates when the action plans were implemented were not included in the documents provided. (129) [s. 30. (1) 4.]

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

RPN #109 stated that all staff are to complete an hourly Resident check and document their observation on a form that was kept on the unit. RPN #109 stated that the resident was not accounted for at 1400 or 1500 hours.

A review of the July 2017, Hourly Resident Check form included the time frame that resident #054 demonstrated a responsive behaviour and identified the home's staff failed to document resident #054's observation on the unit for the following days and times:
July 1, 2017 staff had not documented 9 times; (7-2pm), July 1, 2017 (11pm)
July 2, 2017 staff had not documented 9 times (7-2pm), July 2, 2017 (11pm)
July 3, 2017 staff had not documented 8 times (7-1pm), July 3, 2017 (11pm)
July 5, 2017 staff had not documented 8 times (7-1pm), July 5, 2017 (11pm)
July 6, 2017 staff had not documented 9 times (7-2pm), July 6, 2017 (11pm)
July 7, 2017 staff had not documented 8 times (7-1pm), July 7, 2017 (11pm)
July 8, 2017 staff had not documented 8 times (7-1pm), July 8, 2017(11pm)
July 10, 2017 staff had not documented 9 times (7-2pm), July 10, 2017 (11pm)
July 11, 2017 staff had not documented 4 times (12-2pm), July 11, 2017 (11pm)
July 12, 2017 staff had not documented 8 times (7-1pm), July 12, 2017 (11pm)
July 14, 2017 staff had not documented 8 times (7-1pm), July 14, 2017 (11pm)
July 16, 2017 staff had not documented 9 times (7-2pm), July 16, 2017 (11pm)
July 15, 2017 staff had not documented 4 times (1-2pm), July 15, 2017 (11pm)
July 17, 2017 staff had not documented 8 times (7-1pm), July 17, 2017 (11pm)
July 20, 2017 staff had not documented 8 times (7-1pm), July 20, 2017 (11pm)
July 24, 2017 had not documented 9 times (7-2pm), July 24, 2017 (11pm)
July 25, 2017 had not documented 9 times (7-3pm), July 25, 2017 (11pm)
July 26,2017 had not documented 8 times (7-1pm), July 26, 2017 (1pm)
July 29, 2017 had not documented two times (3pm) and July 29, 2017 (11pm)

Interview with the DOC confirmed, after reviewing these forms, that the staff were required to check and document hourly the resident location and failed to do so as required on the unit. (511) [s. 30. (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 and ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistive Service Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied: 1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD had been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provided for everything required under subsection (5).

The plan of care for resident #012 indicated direction for a PASD device, including where and when to use. The resident was observed on an identified date in January 2018, in the identified location and during the identified time period. Interview with registered staff #109 and #111 confirmed that the resident was had an ability and that the device restricted this ability and could not be removed independently. Staff confirmed that an assessment of the PASD with restraining properties was not completed. Staff also confirmed that the use of this device had been used for other residents in the home and that assessments for the use of the PASD's with restraining properties had not been completed.
Interview with the ADOC on January 10, 2018, confirmed that alternatives to the use of the PASD had not been considered, an assessment of the PASD had not been completed, consent had not been obtained and the PASD had not been approved by a physician, nurse, occupational therapist or physiotherapist. [s. 33. (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 and ensuring that the use of a Personal Assistive Service Device (PASD) under subsection (3) to assist a resident with a routine activity of living may only be included in a resident's plan of care only if all of the following are satisfied: 1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD had been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provided for everything required under subsection (5)., to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received annual training in the area of the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26. (76 (2) 3, 4 & 5).

In accordance with O. Reg. 79/10, s. 219(1) the interval for the purpose of 76(4) of the Act are annual intervals.

The Director of Care and training records provided confirmed that 80 (28%) of all 282 staff had not received training in the areas of the long term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26 in the 2017 calendar year.

(PLEASE NOTE: The above noted non-compliance related to training requirements was identified while inspecting Critical Incident Report inspection log # 007478-17.) (129) [s. 76. (2)]

2. The licensee failed to ensure that staff received annual training in the area of Continence Care and Bowel Management. (76 (2) 11)

a) In accordance O. Reg. 79/10, s. 221(1) 4 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of Continence Care and Bowel Management.

Documents provided and confirmed by the DOC indicated that not all staff who provided direct care to residents in 2017, received training in the area of Continence Care and Bowel Management. Training records provided at the time of this inspection, confirmed that of the 203 staff in the home who provided direct care to residents in 2017, 64 (32%) of those staff had not received the required training in the 2017 calendar year. (506)

b) The licensee failed to ensure that all staff who provided direct care to residents, received annual training in the area of Falls Prevention and Management. (76 (2) 11)

In accordance O. Reg. 79/10, s. 221(1) 4 and 219 (1) the home is required to provide all staff who provide direct care to residents with annual training in the area of Falls Prevention and Management.

Documents provided and confirmed by the Director of Care (DOC) indicated that not all staff who provided direct care to residents in 2017 received training in the area of Falls Prevention and Management. Training records provided at the time of this inspection, confirmed that of the 203 staff in the home who provided direct care to residents in 2017, 64 (32%) of those staff had not received the required training in the 2017 calendar year. (129) [s. 76. (2) 11.]

3. The licensee failed to ensure that all staff who provide direct care to residents received training in the area of Behaviour Management. (76 (7) 3)

In accordance with O. Reg. 79/10, s.221(2) 1, the training intervals for the purpose of subsection 76 (7) of the Act to be completed at annual intervals.

The licensee failed to ensure that all staff who provided direct care to residents receive, as a condition of continuing to have contact with residents, were provided training annually, as required in the area of behaviour management.

Documents provided and confirmed by the DOC indicated that not all staff who provided direct care to residents in 2017 received training in the area of behaviour management. Training records provided at the time of this inspection, confirmed that of the 203 staff in the home who provided direct care to residents in 2017, 64 (32%) of those staff had not received the required training in the 2017 calendar year. (156) [s. 76. (7) 3.]

4. The licensee failed to ensure that all staff who provide direct care to residents received training in how to minimize the restraining of residents and, where restraining was necessary how to do so in accordance with this Act and the regulations. (76 (7) 4)

Documents provided and confirmed by the Director of Care (DOC) indicated that not all staff who provided direct care to residents in 2017 received training in the area of minimizing the restraining of residents. Training records provided at the time of this inspection, confirmed that of the 203 staff in the home who provided direct care to residents in 2017, 64 (32%) of those staff had not received this required training in the 2017 calendar year. (129) [s. 76. (7) 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 and ensuring that mandatory training in relation to the licensee's policy on zero tolerance of abuse and neglect, continence care and bowel management, behaviour management and minimizing the restraining of residents is provided in accordance with the requirements, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15(1) (c) of the Act, the licensee did not ensure that there were schedules and procedures in place for routine, preventative and remedial maintenance.

On January 4, 2018, a tour of all eight shower rooms was conducted. The shower room flooring in two identified home areas was observed to be in poor condition, as water had seeped under the flooring material. Water seeped up from between split seams or from around the floor drain when it was stepped on.

According to records and staff interviews, an audit was conducted of the shower rooms in 2015, and staff #139 provided the management team a list of shower room floors in poor conditions. On March 24, 2015, a quote was provided to management staff #112 for the cost to repair or replace all eight shower room floors. In April 2015, two identified home area shower room floors were replaced, in February 2016, one floor was replaced but the location was not documented and in May 2017, another an identified home are shower room was replace. No other documentation could be provided to determine if another home area shower room floor was previously replaced or if a quote had been obtained to replace it.

1. As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, the licensee did not ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance. On January 4, 2018, a tour of all eight shower rooms was conducted. Two home area shower room flooring was observed to be in poor condition, as water had seeped under the flooring material. Water seeped up from between split seams or from around the floor drain when it was stepped on. According to records and staff interviews, an audit was conducted of the shower rooms in 2015, and staff #139 provided the management team a list of shower room floors in poor condition. On March 24, 2015, a quote was provided to management staff #112 for the cost to repair or replace all eight shower
room floors. In April 2015 two shower room floors were replaced, in February 2016, one floor was replaced but the location was not documented and in May 2017, the another shower room floor was replaced. No other documents could be provided to determine if an identified shower room floor was previously replaced or if a quote had been obtained to replace it.

During a "Peer to Peer Quality" meeting on June 27, 2016, minutes of the meeting included that staff who had conducted room audits reported that an identified shower floor was not in good repair. No remedial repair had been scheduled for the floor. According to maintenance person #140 and the Manager of Programs and Support Services, no schedule to replace two identified shower room floors was in place. Other issues noted during the inspection included lifted and cracked flooring in an identified room (under window area) and lifting near the wall on one side of the an identified dining room. Staff #139 reported that the floor in the identified room was reported to maintenance many months ago and had not yet been fixed.

Light bulbs were burnt out (or ballasts were not operational for the lights) in the six

identified home area tub rooms. Maintenance staff #140 reported that the lights had ballast issues and the entire fixture required replacement. An adequate back up supply was not available at time of inspection and ten additional fixtures were ordered. The reason provided for the lack of timed replacement of the fixtures was due to a retro fit project that was scheduled to start in February 2018, to replace all light fixtures in the home.

Single hung sliding windows located in certain areas of the building were identified by a PSW who was tasked to conduct a focused audit in November 2017, for windows and blinds. Six windows in resident rooms on an identified home area were identified to be drafty and some included having duct tape applied. During the inspection, these windows were all confirmed to have duct tape on the frames. Windows were tested in an identified home area lounge were very difficult to open and close. A window in the Oriole lounge was missing an entire frame on the upper portion. A review of the maintenance request records revealed numerous reports of windows not closing properly or being drafty. At the time of inspection, no long term solution for improving the windows was available.

The licensee's maintenance policies and procedures were reviewed and did not include any preventive procedures related to the condition of the building interior with the exception of large systems such as heating and cooling systems and certain equipment. A policy titled "Maintenance Services (I-BS-44)"dated January 7, 2017, included a purpose "to manage the property in a manner that protect the value of the assets". However, the procedures listed did not include how that would be achieved. The procedures included statements such as; "written policies and procedures shall be developed and maintained for regular maintenance work" and "a preventive maintenance program will be established and maintained to keep the building and equipment in good repair and identify potential capital budget issues". Other policies included remedial procedures or direction for staff to report and document disrepair and how maintenance staff would prioritize the request (M-O-45), and another policy included how maintenance staff were to document the completed work (1-BS-50). No preventive procedures or schedules were established as to what interior building surfaces would be audited, the expected condition of the surfaces or furniture, how often it was to be audited and by whom.

According to Restorative Coach #102, staff from housekeeping, nursing and restorative programs were given the task to audit all of the areas of the home once per month using a "Quality Assurance Monthly Inspection" form. The form included resident rooms, tub and shower rooms and common areas. The items that staff

were to review however, did not include the condition of any furnishings or building surfaces such as floors, walls, doors, fixtures, ceilings, windows or carpets. The form was oriented towards hazards, sanitation and infection control.

The licensee therefore did not ensure that schedules and procedures were in place for remedial or preventive maintenance. [s. 90. (1) (b)] (120)

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 and ensuring the organized program of maintenance services includes schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #15: 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 failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

On January 15, 2018, at 1500 hours the utility room door on an identified home area was propped open. Products identified with a hazardous label were inside and included but were not limited to, bleach stain remover, arjo wipe away, super spill pack and low temp liquid detergent. Product labels identified these substances as corrosive and or poisonous. Interview with RPN #125 confirmed that the door should have been locked and inaccessible at all times when not in use. [s. 91.]

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 and ensuring that all hazardous substances were labelled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was restrained by a physical device under section 31 of the Act, the resident's condition was reassessed and the effectiveness of the restraining device was evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time based on the resident's condition or circumstances.
Interviews with the DOC, the ADOC and RPN #106 and a review of clinical documentation confirmed that resident #010 was not reassessed and the effectiveness of a restraining physical device had not been evaluated every eight hours as required.
RPN #106 confirmed that the restraint flow sheets used in the home required registered staff to place their initials on the document to indicate that the resident had been reassessed and the effectiveness of the device had been evaluated every eight hours while the resident was restrained. RPN #106 and resident #010's plan of care confirmed that the resident was restrained with the use of device whenever the resident used a mobility aid as a care intervention to manage the risk for falling.
Interviews with the DOC, the ADOC, RPN #106 and a review of clinical documentation confirmed that registered staff had not reassessed the resident's

condition or the effectiveness of the device at any time over a two month time period in 2017, when clinical documentation confirmed the resident was restrained with the device every day during the above noted period of time.
At the time of this inspection resident #010 was observed at 1419 hours on an identified date in January 2018, to be using their mobility aid, in a position, with the device applied, not in accordance with manufacture instructions. The resident was again observed at 1015 hours on another date in January 2018, to be using their mobility aid, in a position, with the device applied, not in accordance with manufacture instructions. Both of the above noted observations were brought to the attention of RN #103 and RPN #106 respectively. The Physiotherapist, the Restorative Coach and RPN #106 confirmed that the resident was independently with their aid resulting in repositioning which caused the device to readjust. The above noted staff, who provided care to the resident, were aware of these circumstances and confirmed that no action had been taken to reassess the resident's condition or the effectiveness of the restraining device. [s. 110. (2) 6.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that every release of the device and all repositioning was documented.

Resident #010 was noted to be utilizing a mobility aid, with a device in place, on two dates in January 2018. The resident's plan of care included a care focus related to a risk for falls and interventions to manage this risk included the use of a device, which the resident was unable to remove and was initiated in August 2016. Documentation made by Personal Support Workers (PSW) related to the release of the restraint and the repositioning of resident #010 indicated that for 22 days in one month in 2017, and for 23 days in another month in 2017, staff had not released the restraint and repositioned the resident every two hours. This clinical documentation indicated that staff had not released the restraint or repositioned the resident for periods of time that ranged from four to nine hours. It was noted that the resident's current care plan indicated that they had areas of altered skin integrity.
The Director of Care (DOC), the Assistant Director of Care (ADOC) and RPN #106 confirmed that documentation made by PSWs during the above noted periods of time indicated that they had checked the resident when they documented "OK" but had not documented that they had repositioned the resident every two hours when they failed to document that they had released and repositioned the resident as was required. [s. 110. (7) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that when a resident was restrained by a physical device under section 31 of the Act, the resident was released from the physical device and repositioned at least once every two hours and the resident's condition was reassessed and the effectiveness of the restraining device was evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time based on the resident's condition or circumstances., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 135. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug.
Staff failed to report medication incidents involving resident #020, resident #021, resident #022 and resident #023 as required.

i. Resident #020 had a designated Substitute Decision Maker (SDM) for both personal care and finances. On an identified date in 2017, staff documented on a Medication Incident/Near Incident Report (MINIR.) The MINIR provided an opportunity for staff to document if they had notified the resident and/or the SDM, pharmacy or physician. Documentation on the MINIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

ii. Resident #021 had a designated SDM for both personal care and finances. On an identified date in 2017, staff documented on a MIR that the resident did not receive their medications as ordered. The MINIR provided an opportunity for staff to document if they had notified the resident's physician and the SDM. Documentation on the MINIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

iii. Resident #022 had a designated Substitute Decision Maker (SDM) for both personal care and finances. On an identified date in 2017, staff documented on a MINIR that the resident did not receive their dose of an identified medication. The MINIR provided an opportunity for staff to document if they had notified the resident and/or the SDM, pharmacy or physician. Documentation on the MINIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

iv. Resident #023 had a designated SDM for both personal care and finances. On

an identified date in 2017, staff documented on MINIR that the resident did not receive a medication as ordered. The MINIR provided an opportunity for staff to document if they had notified the resident's SDM. Documentation on the MINIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

An interview with the ADOC on January 9, 2018, and a review of clinical records confirmed that there was no evidence that resident #020's, #021's, #022's and #023's SDMs were notified of the above noted medication incidents, that resident #020's, #021's and #022's physician was notified that a medication incident had occurred or that the pharmacy had not been notified of medication incidents involving resident #020 and resident #022. (506) [s. 135. (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 and ensuring that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the emergency plans dealt with a loss of one or more essential services.

On January 11, 2018, the magnetic locking system for the identified stairwell doors failed. The doors were therefore unlocked between 1500 hours and 2300 hours. According to maintenance staff, a component on a power supply circuit board failed. Inspectors #129 and #506 were in the building at the time of the incident and overheard a staff member report to the Director of Care that stairwell doors were unlocked. At approximately 1510 hours the inspectors toured an identified floor and found one particular stairwell door unlocked and no staff supervising the door in one home areas. The RPN in the home area was aware that the stairwell doors were unlocked. The inspectors subsequently spoke to the Manger of Programs and Support Services at approximately 1537 hours and asked if they were aware of the unlocked doors. The Manger was not aware and informed the Director of Care. The Director of Care arranged to have staff supervise the doors to ensure that residents did not exit the building or fall in the stairwells. The plan to arrange to have the doors fully supervised took 45 minutes. The licensee's emergency plans did not include any direction for staff to follow in the event of a loss of one or more essential services. These services include power, elevator, heat, the resident-staff communication and response system or door access control systems (safety). [As per s. 9(1)(4) and s. 19 of O. Reg 79/10] [s. 230. (4) 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 and ensuring that the emergency plans dealt with a loss of one or more essential services, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the continence care and bowel management program provided for an annual evaluation of the residents' satisfaction with the

range of continent care products in consultation with residents, Substitute Decision Makers (SDM) and direct care staff.

An interview with the Director of Care (DOC) and a review of the Satisfaction Survey sent to resident's families on April 12, 2017, confirmed that the survey did not seek information related to the satisfaction with the range of continent care products available in the home. Three questions on a 41 question survey were identified as "Continence Care". These three questions asked for information about the care the resident received and there was no indication that respondents were asked to evaluate the range of continence products available in the home.
The DOC was asked to provide documentation to verify that direct care staff were consulted in relation to the satisfaction with the range of continent products available in the home and at the time of this inspection they were unable to provide any evidence that Registered Nurses (RNs), Registered Practical Nurses (RPNs) or Personal Support Worker (PSW) staff participated in the annual evaluation. PSW #119, PSW #121 and PSW #122 confirmed they had not participated in an evaluation of the satisfaction with the range of continence care products available in the home.
The licensee failed to undertake an evaluation of the residents' satisfaction with the range of continent care products in consultation with residents, Substitute Decision Makers (SDM) and direct care staff for the 2016 calendar year. (129) [s. 51. (1) 5.]

2. The licensee failed to ensure that the residents who were incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The Minimum Data Set (MDS) assessment completed on an identified date in 2017, for resident #015, indicated their continence status. The following MDS assessment completed three months later, indicated that the resident's continence level had changed. Interview with the ADOC on January 9, 2018, confirmed that the resident did have a change in their continence level and did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment specifically designed for assessment of incontinence.
An interview with the ADOC and a review of clinical documentation confirmed that

when resident #015's continence level deteriorated they were not assessed as required. (506) [s. 51. (2) (a)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record relating to each evaluation that included: date of the evaluation, the names of the persons who participated, summary of the changes made, and the date that those changes were implemented.

The licensee has failed to ensure that there was a written record relating to each evaluation that included the dates that any changes were implemented.

A review of the documents provided by the DOC and an interview with the DOC revealed that the program evaluation for 2016 related to the management of responsive behaviours was completed on February 22, 2017, however, the dates of any changes implemented were not included on the program evaluation. [s. 53. (3) (c)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that following the annual evaluation of the effectiveness of the licensee's policy under section 20 of the Act to promoted zero tolerance of abuse and neglect, the written record of the evaluation contained the dates that the changes and improvements identified during the evaluation were included in the written record.
The Director of Care (DOC) provided a document they identified as the most recent evaluation to determine the effectiveness of the licensee's policy related to the prevention of abuse and neglect. The document indicated the evaluation had occurred on September 6, 2017. The DOC and the document provided confirmed that the written record of the evaluation did not include the date(s) changes and improvements identified in the document were implemented.

(PLEASE NOTE: The above noted non-compliance related to the annual evaluation of the effectiveness of licensee's policy under section 20 of the Act, was identified while inspecting Critical Incident Report inspection log # 007478-17.) [s. 99. (e)]

WN #22: 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).

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):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home immediately under subsection (4); 2. An unexpected or sudden death, including a death resulting from an accident or suicide.

i) According to a CIS, that was submitted to the Director on an identified date in 2017, resident #001 passed away both sudden and unexpectedly on an identified date. The DOC confirmed on January 11, 2018, that the resident's passing was both sudden and unexpected and the Director was not informed immediately as was required and the registered staff are aware of the Ministry's after hours emergency contact.
(Please Note: The above noted non-compliance related to notification of the Director was identified during Critical Incident Inspection #028953-17.) (506) [s. 107. (1) 2.]

2. The licensee of a long-term care home failed to ensure that the Director was 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): 4. Any missing resident who returned to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
A review of Critical Incident System (CIS) report described that on an identified date in 2017, a resident went missing from the home and was later returned to the home diagnosed with an injury. The Resident Care Coordinator (RCC) confirmed the Director was notified, through their submission of the CIS report, two days after the resident returned to the home. The RCC confirmed they had knowledge of the immediate need to report this incident. The RCC further confirmed registered staff had the ability to report after regular business hours. (511) [s. 107. (1) 4.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that in a home with a licensed bed capacity of 97 beds or more, the home's Administrator worked regularly in that position on site at least 35 hours per week.

St. Joseph's Lifecare Centre is a 205 licensed bed long term care home.

At the time of this inspection the Administrator confirmed that they were in an interim role at the home while the licensee completed a search for a permanent Administrator and that this had been the case since November 2017. The Administrator confirmed that it had been their practice to work two full days in the home (16 hours) unless there was an emergency or a planned meeting at the home. Throughout the course of this inspection it was noted that the Administrator had not worked the required number of hours on site at the home. [s. 212. (1) 3.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Director of Care was asked to provide the most recent annual evaluation of the training and orientation program. At the time of this inspection the Director of Care, the Assistant Director of Care and the previous Director of Care were unable to provide evidence that the training and orientation program in the home had been evaluated. [s. 216. (2)]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 217. The licensee shall ensure that there is a designated lead for the training and orientation program. O. Reg. 79/10, s. 217.

Findings/Faits saillants :

1. The licensee failed to ensure there was a designated lead for the training and orientation program.

The Director of Care indicated that staff #102 was the designated lead for the training and orientation program. When interviewed staff #102 confirmed that they maintained the computerized training platform but did not engage in any other activities related to the training and orientation program, were unaware that they had been identified as the lead for this program and were unaware of the role expected of the lead the home's training an orientation program. [s. 217.]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee did not ensure that approval of the Director was received prior to commencing any alterations, additions or renovations to the home.

On January 17, 2018, within the designated long term care home, an eye doctor's office was observed on the fourth floor with public access. The majority of the fourth floor was established for long term care staff offices, meeting rooms and a photocopier room. A small section of the fourth floor was designed and approved by the Director to include a small public area, with medical offices, segregated by a lockable door (physical barrier between public and long term care areas) and serviced by one elevator. The eye doctor's office was not located in the segregated area. According to the receptionist for the eye doctor's office, the office was established in the current location eight years prior. According to a long term care maintenance employee, the space that was being occupied by the eye doctor's office was formerly a staff lunch room and an office for long term care staff. No approvals or documentation could be provided by the licensee that they received approval to alter or convert the space to an eye doctor's office. [s. 305. (3) 1.]

Issued on this 29 day of May 2018 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by PHYLLIS HILTZ-BONTJE (129) - (A2)

Inspection No. / No de l'inspection : 2018_587129_0001 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 029183-17 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 29, 2018;(A2)

Licensee / Titulaire de permis : St. Joseph's Health System
50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6

LTC Home / Foyer de SLD : St. Joseph's Lifecare Centre
99 Wayne Gretzky Parkway, BRANTFORD, ON, N3S-6T6

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

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

Ministère 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

To St. Joseph's Health System, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing "Bed Entrapment and Assessment " form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003). This document is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". The amended questionnaire shall, at a minimum, include:

a) questions that can be answered by the assessors related to the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b) the alternatives that were trialled prior to the application of one or more

bed rails and document whether the alternatives were effective during the specified period of time; and
c) include the names of the interdisciplinary team members who participated in evaluating the resident; and
d) provide clear written direction or alternative (i.e decision tree) to assist the assessor(s) in answering the questions when determining whether bed rails are a safe alternative for the resident being assessed.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed entrapment and assessment form and document the assessed results and recommendations for each resident. The assessment document is to be included in the resident's clinical record.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards.

4. Obtain or develop an education and information package that can be made available for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, how beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts associated with bed systems and the use of bed rails.

5. Amend the "Medical Beds and the Potential for Resident Entrapment (5-RS-35) " policy and associated forms and procedures to include all of the above noted requirements and any additional relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". All registered and non-registered staff shall be informed about the amended policy, forms and procedures.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Regulation 79/10.
The non-compliance was issued as a CO due to a severity level of 2 (minimal harm or potential for actual harm/risk) a scope of 3 (widespread) and a compliance history of 4 (ongoing non-compliance with a VPC or CO under the same section) issued on November 24, 2015, as a VPC and December 15, 2016, as a VPC.

2. The licensee did not ensure that where bed rails were used, that the resident was assessed and his or her bed system evaluated in accordance with prevailing practices to minimize risk to the resident.

A companion guide titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used. The clinical guidance document is cited in a document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008”, and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

Nine residents (#001, #002, #003, #004, #006, #007, #008, #009, #060) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. A restorative coach, identified themselves as the person who completed many of the resident assessments, including several that were reviewed. The assessment was determined to be missing several procedures in identifying the risk over the benefits of bed rail use for residents using one or more bed rails.

a) The licensee’s policy and procedure titled “Medical Beds and the Potential for Resident Entrapment (5-RS-35)” did not include any procedures related to how a resident would be clinically assessed for bed related safety hazards while in bed with bed rails applied. The policy included direction that “each resident and bed system would be assessed to determine if the system that they are using is appropriate and safe for them” and that “residents are assessed on admission, change in condition or when their bed system was changed”. The policy did not include who would be involved in the assessments, what form or tool would be used to collect appropriate information about the resident’s condition, their risk factors for bed safety related

hazards and ability to use bed rails safely or a reference to the above noted clinical guidance document for additional guidance. A memo dated November 18, 2016 addressed to "all staff" from the Director of Care included information that restorative coaches would complete a "Bed Entrapment Assessment" upon admission and that "bed rails will be removed as they are considered best practice due to risk for entrapment" and that families/residents had the option of either no bed rails or an assist bar for bed mobility.

b) The "Bed Entrapment Assessment" form included two sections. The first section included 10 questions requiring a "yes" or "no" answer related to the resident's cognition, size of head, evidence of involuntary movements, overall mobility, ability to get out of bed unsupervised and ability to use the bed remote. The conclusion included if bed rails would be used and if so, the type that would be applied. The second section included what zones of entrapment passed or failed on the resident's bed. Restorative Coach (RC) #102 reviewed several of the assessments with inspector #120 and #506 to determine what collaborative or interdisciplinary approach was taken when completing the assessments. The RC reported that they acquired the answers to some of the questions to complete the first section from an RN. The questions related to bed mobility, transfer abilities and use of bed remote were assessed by the RC. An interdisciplinary team was not developed to clinically assess each resident who was provided with any type of device on their beds, whether an assist bar, assist rail or bed rail (of any size). According to the clinical guidance document, the composition of the interdisciplinary team may vary depending upon the nature of the care and service setting and the resident's individual needs. Team members for consideration include, but are not limited to: nursing, social services, physicians (or their designees); rehabilitation and occupational therapists; patient; family (or authorized representative); and medical equipment suppliers. The RC #102 reported that PSWs, who spent a lot of time with the residents, were not involved in the assessments and registered staff were minimally involved by providing answers to some of the questions. The "Entrapment Assessments" completed for all of the residents reviewed included only one signature, that belonging to the RC.

c) Documentation for nine out of the nine residents that were reviewed did not include any information about the resident's sleep or night time habits, medical condition, pain, medication use, existence of delirium, continence patterns, behaviours, falls risk or communication abilities, as potential risk factors for increased bed related injuries, entrapment, suspension and entanglement where bed rails were

applied. Some of these factors were identified in the written plan of care for each resident, but were not reviewed in relation to bed safety. A resident sleep observation process after bed rails were applied was not included in the overall resident assessment process. According to the clinical guidance document, each resident has differing sleep and night time habits and a period of time is required while the resident is in bed, if bed rails have been applied, that best identifies how residents interact with the bed rails during various stages of sleep.

The RC did not observe any of the eight residents in bed throughout the night to determine what safety hazards were identified, if any. The RC provided a document for review titled "General Device Guidelines" which was given to them by former management staff, who were no longer available in the home. The document included direction for the RC to assess residents visually on admission for "bed system modifications" such as "assist bars and bed rails" and to complete a bed entrapment evaluation only on those beds that had "full or partial bed rails". If the resident was provided with "assist bars", zones 1-4 (in and around the bed rail) were not evaluated for entrapment zones 1-4. The RC explained that they did not consider the "assist bars" located on many of their beds as "bed rails" because they were only 12 inches wide. The "General Device Guidelines" for the registered staff included the requirement to complete documentation that the resident provided consent for the use of the bed rails, that residents were monitored while the device (bed rail) was applied and whether an alternative was trialled. The documentation requirement was only required if the bed rail was either a restraint or limited or inhibited the resident from getting out of bed. Residents with an "assist bar" therefore were not included in any structured form of monitoring or assessment.

According to the Clinical Guidance document, "in creating a safe bed environment, the general principle that should be applied includes the automatic avoidance of the use of bed rails of any size or shape". The definition of a bed rail is "an adjustable metal or rigid plastic bars that attaches to the bed, that are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths". Once bed rails are applied, residents would need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk-related hazards associated with their bed rails. The risk-related hazards include but are not limited to strangling, suffocation, bruising or injury against the bed rail, suspension around a bed rail (if centrally located on the bed), entanglement and entrapment. The licensee's policy would need to establish who would monitor the residents, for how long and what specific hazards would need to

be monitored while the resident was in bed with one or more bed rails applied for all of the previously mentioned hazards.

d) According to RC #102, the "Memo" dated November 18, 2016, included an attachment or fact sheet titled "Bed Systems and Safety", which was provided for review. It included information about entrapment deaths in Canada, the benefits and risks of bed rail use and what changes were being made in the home. The fact sheet included the following statements; "bed rails will be removed from bed systems, if they are not required" and "bed rails will be replaced with assist bars, which provide a device on the bed system that allows the resident something to hold on to, without the risk of entrapment". The licensee's understanding of the potential hazards associated with assist bars was not in accordance with the clinical guidance document.

e) Nine out of the nine clinical bed safety assessments that were completed within the last 12 months did not include what bed rail alternatives were trialled before the bed rails were applied. The "Entrapment Assessment" form did not include an area for the assessor to complete related to what alternatives were trialled, when they were applied, for how long and whether successful or not. The residents' clinical records (progress notes) were reviewed and did not include any reference to alternatives trialled. The licensee's bed safety policy did not reference or include any options such as transfer pole, bed rail guards or padding, height adjustable bed, raised perimeter mattress (easier to grab than a flat mattress when being repositioned) or adjustable bolsters (also known as soft rails). The licensee's bed safety policy did not include what strategies, accessories or options were available to staff and the resident if certain bed safety risks were identified such as suspension, bruising, entanglement or entrapment (for the various different zones).

f) Loose bed rails were noted on three resident beds, creating a condition that could increase the likelihood of bed related injury or entrapment for the resident. Depending on the type of bed rail attached to the frame, the frequency of use and the type of hardware used to attach the bed rails to the frame, loose connections can occur. The bed systems in the home consisted of five different types of bed rails. These included an assist bar (with easy pull knob release allowing rail to rotate up or down), a quarter length plastic moulded "half-head" side rail which could be lowered up or down, a plastic moulded 3-position assist side rail which could be rotated 90 degrees (towards or away from the mattress), a quarter length "head rail" with three positions (low, normal guard and high) that could be lowered up or down and a metal

assist rail (with easy pull knob release allowing bed rail to rotate 180 degrees into 3 different positions, guard, assist or transfer). The licensee however had identified the names of the bed rails as either half rails or assist bars.

Resident #006 was not in bed and it was noted the bed was equipped with two bed rails which were both elevated. The bed rail on the resident's right side was loose, creating a gap between the bed rail and the mattress (end of bed rail) large enough for the inspector #120's knee to fit into the space. The resident's plan of care included the need to apply both "half rails" for the resident to engage in activities of daily living. The RC and maintenance staff were unaware of the loose bed rail and stated that the staff did not report the issue.

Resident #060 had one rail on the bed on the specified side. The licensee identified the rail as an "assist bar". The resident's plan of care identified that the resident needed one assist bar to assist with positioning. The assist rail was constructed so that the bed rail could be attached or removed by pressing a release button on the side of the rail. The connections between the holder attached to the frame of the bed and the bed rail itself was loose, causing the assist rail to swivel away from the mattress, creating a minor gap large enough for an arm to slip between the mattress and the rail.

g) Resident #002 was in bed at the time of observation with both of their assist bed rails attached and in the guard position. The resident reported that they did not use the bed rails other than to grab on to them when staff completed care. Their written plan of care included that the resident had two half rails and seven other care focus areas that could impact on the resident's interaction with their bed system. The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). Bed related risk factors were present, as identified on the plan of care and partially on the "entrapment assessment", however they were not analyzed as part of the overall assessment. The resident was not assessed in accordance with prevailing practices as identified. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted. No risk over benefit conclusion was made with respect to the application of the assist bed rails for this resident.

h) Resident #004 did not have an "entrapment assessment" completed and was admitted to the home in 2011. The resident was in bed when observed with both side

rail elevated. Their written plan of care included that the resident was to have two bed rails applied when in bed to aid with positioning and seven other care focus areas that could impact the resident's interaction with their bed system. Bed related risk factors were present, as identified on the plan of care, however they were not analyzed as part of the overall assessment. The resident was not assessed in accordance with prevailing practices as identified. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted. No risk over benefit conclusion was made with respect to the application of the assist bed rails for this resident.

i) Resident #007 was in bed at the time of observation, with both of their rails in a transfer assist position. Staff #100 and #101 confirmed that they did not use the bed rails other than to grab on to them when staff completed care and this was not always the case it depended on the resident. Their written plan of care included that the resident had two rails to aid in positioning and five other care focus areas that could impact the resident's interaction with their bed system. The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

j) Resident #008 was in bed at time of observation, with both their rails in a transfer assist position. Staff #100 and #101 confirmed that the resident uses the rails to roll over and reposition themselves while in bed. Their written plan of care included that the resident had two rails to aid in positioning and help with activities of daily living care and three other care focus areas that could impact on the resident's interaction with their bed system.The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

k) Resident #009 used two assist bars in bed and at the time of the observation it was noted that both of their rails in a transfer assist position. Staff #100 and #101 confirmed that the resident uses the rails to roll over and reposition themselves while

in bed and assist with transferring out of bed. Their written plan of care included that the resident had two rails to aid in positioning and help with activities of daily living care and six other care focus areas that could impact on the resident's interaction with their bed system. The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

l) Resident #001 used two assist bars in bed for transferring and positioning as confirmed through clinical record review. Staff #100 and #101 confirmed that the resident used the rails to roll over and reposition themselves while in bed and assist with transferring. Their written plan of care included that the resident had two rails and eight other care focus areas that could impact on the resident's interaction with their bed system.The written plan of care did not include any information about their bed rail use, why they were applied, on what side, or when they should have been applied (when in bed, during staff supervision or throughout the day). The resident was not assessed in accordance with prevailing practices as identified above. No alternatives were documented as trialled and observations related to bed rail use and potential risk was not conducted.

m) Bed systems that included all bed rail styles with the exception of bed rails styles from two identified suppliers were not evaluated for entrapment zones 1-4. According to RC#102, all other bed rail styles were not considered to be "bed rails" when they were purchased and they did not receive any evaluations using a specialized tool designed to measure the fit and compression of mattresses in and around an attached device. (120)

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

Aug 28, 2018

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

(A1)(Appeal/Dir# DR# 081)
The following Order has been rescinded:

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Order # / Ordre no : 003
Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall complete the following:

1. Connect all doors that are between any non-residential LTC resident areas to public areas or areas used by non-LTC staff, the main foyer door, stairwell doors and the door located between the public area and the LTC home side on the fourth floor to the resident-staff communication and response system.

2. All of the doors listed in #1 above shall have an audible door alarm at the door that can be cancelled only at the point of activation (at the door).

3. Develop a written policy and procedure that deals with when doors to balconies shall be locked and unlocked. The policy and procedure shall be implemented.

4. Develop a procedure for designated staff to include regular and routine door checks to their routines to ensure doors to balconies, stairwells, non-residential areas and the outside are locked. The procedure shall be implemented.

5. All staff shall be oriented to the above required policies and procedures and documentation shall be kept as to who received the orientation, when it was given and by whom.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Regulation 79/10. The non-compliance was issued as a CO due to a severity level of 2 (minimal harm or potential for actual harm/risk) a scope of 3 (widespread) and a compliance history of 2 (previous unrelated non-compliance).

2. The licensee did not ensure that the following rules were complied with:

All doors leading to stairways and the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. connected to the resident-staff communication and response system.

The long term care home was equipped with three stairwell doors located in each of the 8 home areas. Other doors to which residents had access and lead directly to insecure outdoor areas included the main entrance door. Each door was equipped with a door access control device, which included a key pad next to each door and magnets on the door and frame. The doors remained locked until a code was entered on the key pad to release the magnets. Random doors and the main entrance door were selected to test the door access control system. Stairwell doors labelled 2-3, 9-3, 1-3, 8-3, 3-3, 2-2, 2-1 and the main entrance door were held open for two minutes once they were unlocked. After two minutes, no audible door alarm sounded at the doors.

The long term care home's resident-staff communication and response system was equipped with activation stations (in each resident accessible area), a visual component in the form of dome lights and an audio component, which included portable phones carried by health care aides. When an activation station was activated, the phones alerted staff to the location of the call. All stairwell doors and the main entrance door were required to be connected to this system. However, the main entrance door and the above noted stairwell doors that were tested were not connected to the resident-staff communication and response system. The doors were tested by holding the doors open for two minutes and waiting for the portable phones carried by health care aides to sound. The doors were confirmed to be unlinked to the resident-staff communication and response system. The registered staff and health care aides who were in the home areas at the time of testing, stated that their portable phones did not alert them to any open doors. The registered staff were unaware that stairwell doors should have alarmed if they did not close properly or were held open for too long. A maintenance person who was very familiar with the various building systems stated that they were unaware that the stairwell doors and the main entrance door were required to be connected to the resident-staff communication and response system and did not test the system themselves to ensure that it was functional.
(120)

2. The licensee did not ensure that the following rule was complied with:

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

A specified activity room balcony door was equipped with a slide lock, but the lock was not engaged to restrict unsupervised access to the balcony by residents on two identified dates in January 2018. The RN who was on duty was unaware of the unlocked balcony door and was asked if they had the key to lock it. The RN was subsequently observed locking the balcony door.

A specified activity room balcony door was equipped with a slide lock, but the lock was not engaged to restrict unsupervised access to the balcony by residents in January 2018. The RN who was on duty, was unaware of the unlocked balcony door and was asked if they had the key to lock it. The RN could not find a key and directed a staff member to monitor the door while they tried to get assistance in finding the key.

The registered staff were each asked if it was part of their routine to check the balcony doors to ensure they remained unrestricted when unsupervised. Several of the registered staff reported that it was not a task that they conducted. (120)

3. The licensee did not ensure that the following rules were 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.

The long term care (LTC) home included non-residential areas consisting of medical and non-medical related offices on the fourth floor that were accessible to the public from the ground floor. The fourth floor, which was designated for long term care staff offices, was segregated by a door which led to the medical and non medical offices or public area. The public area also consisted of one passenger elevator (also included access to the fifth floor, a non LTC area). One of the offices was advertised being open on the weekends. The public was observed using the elevator on two identified dates, to access these offices and a medical clinic located in the LTC home corridor. The door that segregated the LTC home side from the public side was equipped with a magnetic locking system and a key pad next to the door. During the inspection the door was not supervised by any staff and was not locked to restrict unsupervised access to the public area by residents on two identified dates. Two elevators located on the LTC home side were easily accessible to residents that resided on three other floors. However, if a resident exited the elevators on the fourth floor, they required a code to get back onto the elevator. If the resident did not know the code, they could not get back down to their floor without staff assistance. Once on the fourth floor, the resident would have easily been able to use the public elevator and get down to the ground floor and outside of the home or to the fifth floor. Staff member #139 reported that they had seen residents on the fourth floor numerous times in the past, especially on weekends when LTC staff were not available to re-direct them back to their home areas. (120)

4.
(120)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Nov 28, 2018(A2)

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall audit all windows in the home to which residents have access. Any windows that are identified to open more than 15 centimetres shall have a restriction device installed. The restriction device must not be easily removed by residents or staff. The windows shall be checked routinely to ensure that restriction devices remain on the windows.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Regulation 79/10. The non-compliance was issued as a CO due to a severity level of 2 (minimal harm or potential for actual harm/risk) a scope of 2 (a pattern) and a compliance history of 2 (previous unrelated non-compliance).

2. The licensee did not ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres (cm).

Certain areas of the long term care home were equipped with single hung windows that were designed to slide open vertically, with double panes. They were located in resident bed rooms, dining rooms and lounge areas on each home area. These windows were observed to be missing a device to restrict the windows from being opened more than 15 cm. On January 4, 2018, an interior pane window was observed to be open more than 20 cm in a lounge on a specified home area. Neither of the two panes had a restriction device in place. Subsequently, a random number of windows were selected for review. The widows were missing a restriction device in the additional areas. The observations were reported to the Manger of Programs and Support Services, who was unaware of the issue. The manager was informed that the number of windows without the device may include additional windows and that a home wide check would identify any missed during the random inspection completed. On January 16, 2018, windows located in several areas were found unrestricted.The observations were reported to a maintenance person for follow up. The maintenance person reported that checks or audits to ensure windows did not open more than 15 cm were not done by staff in the home. (120)

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

Mar 08, 2018

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

Ministère 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 : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to:

1. Identify and implement interventions to minimize the risk of altercations and potentially harmful interactions between residents #025, #042, #044 and #045 and other residents.

2. Ensure all direct care staff who are involved in the care of these residents, are aware and trained in the interventions identified above.

3. Review and revise if necessary any policies and procedures related to the management of responsive behaviours and implementation of interventions to ensure that these documents provide clear directions to staff.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Regulation 79/10. The non-compliance was issued as a CO due to a severity level of

(actual harm/risk) a scope of 2 (a pattern) and a compliance history of (previous unrelated non-compliance).

2. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #025, #042, #044 and #045 and other residents, by identifying and implementing interventions.

a) Resident #025's clinical record indicated they demonstrated responsive behaviours towards co-residents. In 2017, two days apart, resident #025 engaged in altercations with resident #042 and resident #010. These altercations resulted in superficial injuries to both residents. A review of the care plan in place for resident #025 at the time of the above noted altercations did not include interventions to prevent altercations with co-residents. After the two incidents the home did not identify nor implement any new interventions to minimize risks of altercations among residents. An interview with the Resident Care Coordinator (RCC) confirmed at the time of the incidents the home did not take steps to minimize the risk of altercations and potentially harmful interactions between and among residents. (506)

b) Resident #042's clinical record indicated they demonstrated responsive behaviours towards co-residents. Resident #042's clinical record confirmed that the resident engaged in altercations with co-residents on more than one occasion. The plan of care in place at the time of these altercations did not include interventions to prevent altercations with co-residents. The home did not identify nor implement any new interventions to minimize risks of altercations among residents. An interview with the RCC confirmed at the time of the incident the home did not take steps to minimize the risk of altercations and potentially harmful interactions between and among residents. (506)

c) Resident #044's clinical record indicated they had diagnoses related to cognitive function. On an identified date in 2016 resident #044 had an altercation with resident #043 during which resident #044 sustained an injury. A few days following the identified incident resident #044 and resident #043 were again involved in an altercation that resulted in resident #043 sustaining an injury that required treatment in hospital.
Interview with registered staff #132 and ADOC on January 17, 2018, confirmed that steps were not taken to minimize the risk of altercation and harmful interaction between resident #044 and #043 following the above noted incident and that no new intervention were identified or implemented after the altercation following which

resident #043 was transferred to hospital. (156)

d) Resident #045's clinical record indicated the resident demonstrated responsive behaviours towards co-residents. On an identified date in 2016, resident #045 and resident #047 engaged in an altercation. This altercation resulting in resident #047 sustaining an injury. Earlier that day, resident #047 was in an altercation with resident #033 which resulted in an injury. Interview with registered staff #106 on January 23, 2018, confirmed that steps were not taken to minimize the risk of altercation and harmful interaction between resident #045 and #047 and that no new interventions were identified or implemented to prevent the interaction of these two residents following the above noted altercations.

On an identified date resident #045 engaged in an altercation with resident #032 which resulted in injury to resident #032. Interview with registered staff #106 on January 23, 2018, confirmed that steps were not taken to minimize the risk of altercation and harmful interaction between resident #045 and #032 and that no new interventions were identified or implemented to prevent the interaction of the two residents following the above noted incidents.

(506)

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

May 29, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to:

1. Protect all residents, including resident #032, resident #047 and resident #035 from abuse by anyone.

2. Review and revise the policies and procedures related to the prevention of abuse and neglect and ensure that these documents provided clear direction to staff related to what constitutes abuse and neglect as well as actions to take to prevent abuse.

3. Provide face to face training for all staff related to the revised policies and procedures noted above. All documentation related to the content of the training program and attendance at those programs is to be maintained by the home.

4. Develop and implement an auditing/monitoring tool to ensure the above noted policies and procedures are complied with.

Grounds / Motifs :

1. This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Homes Act, Regulation 79/10. The non-compliance was issued as a CO due to a severity level of 3 (actual harm/risk), a scope of 2 (a pattern) and a compliance history of 4 (ongoing non-compliance with a VPC or CO under the same section) issued as a VPC during the 2016 RQI which was initiated on December 15, 2016.

2. The licensee failed to protect resident #035 from abuse by co-resident #034.

In accordance with O. Reg. 79/10, s. 2(1) abuse is defined as, "any non-consensual touching, behaviours or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

Clinical documentation and a Critical Incident Report (CIR), submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated resident #035 was abused by co-resident #034.
Personal Support Worker (PSW) #133 confirmed that resident #035 demonstrated what they believed to be a limited understanding of issues occurring around them.
Registered Practical Nurse (RPN) #138 confirmed that they believed resident #035 would not have been able to consent due to a cognitive impairment. RPN #138 confirmed that co-resident #034 understood their actions.
PSW #133 and a written statement they provided to the Director of Care (DOC) at the time of the incident, confirmed that on and identified date in 2017, they observed the co-resident move themselves up to resident #035. PSW #133 indicated in the statement that the co-resident placed themselves in a position which prevented resident #035 from removing themselves from the situation. The co-resident was then observed by PSW #133 to speak to resident #035. PSW #133 immediately intervened to remove the co-resident from the area and reported this incident to their supervisor.
The licensee failed to protect resident #035 from abuse.

a) The licensee failed in their duty to protect resident #035 from abuse when identified behaviours of the co-resident were not assessed and care interventions were not put in place to manage those behaviours.
During an interview on January 19, 2018, RN #134 was asked if they had been made aware of staff's concern about unusual behaviour that had been demonstrated by the co-resident towards co-residents and they responded "we were watching the co-resident because we felt we had to". RN #134 was unable to identify specifically why they thought they felt they had to watch the co-resident.

Prior to the above noted incident, clinical documentation made by registered staff in the co-resident's clinical record indicated that the resident had been seen to place themselves in front of another co-resident. The co-resident became agitated with this behaviour and attempted to walk away from the co-resident, the co-resident then

continued to follow the other co-resident around the home area.
During an interview on January 19, 2018, RPN #135 stated that the day prior to the incident noted above, "there was some inclination that there were some behaviour problem" with the co-resident and they "had a weird feeling" about the co-resident. RPN #135 confirmed that they were in the vicinity of when the above noted incident occurred.
PSW #133, who observed the incident, submitted a written statement to the DOC. In the statement PSW #133 indicated that they had been aware for a few days prior to the incident that the co-resident had been following resident #035 around two home areas. During an interview conducted via telephone on January 19, 2018, PSW #133 confirmed their concern about the co-resident's behaviour and that they were aware staff had been watching the co-resident due to their concern for other co-residents. The information provided by PSW #133 during the interview was consistent with the written statement they had provided to the DOC at the time of the incident.
Although clinical documentation indicated that staff communicated to an official who attended the home following the incident, that the doors had been closed to limit residents from going to the common elevator area for the time being, that they would consider moving the co-resident to another floor if there were any signs of distress by resident #035 and that they would monitor the co-resident for a possible infection, there were no care interventions placed in either the co-resident's or resident 035's plan of care related to the above noted actions. Documentation in the clinical record indicated that during the evening of the following day, there was another interaction between resident #035 and the co-resident when as resident #035 walked by the co-resident's room a staff member overheard the co-resident attempting to have resident #035 enter into their room.
RN #134, RPN #135 and clinical documentation confirmed that the behaviours the co-resident had been reported to demonstrate had not been assessed and the co-resident's plan of care had not been reviewed or revised in order to manage those behaviours and protect co-residents either before the incident noted above, or after this incident was reported and investigated.

b) The licensee failed in their duty to protect resident #035 from abuse when they failed to ensure that all staff received the mandatory training related to the prevention of abuse and neglect in the 2017 calendar year. Training records provided by the DOC confirmed that 28% of all staff had not received the required training.

c) The licensee failed in their duty to protect resident #035 from sexual abuse when they failed to ensure that the written policy to promote zero tolerance of abuse and

neglect clearly identified what constituted abuse. The licensee's policy "Resident Abuse", identified as 1-NR-161, last revised on August 18, 2017 did not provide any direction related to what constituted sexual abuse and did not identify what constituted emotional abuse, financial abuse, physical abuse or verbal abuse as defined in O. Reg 79/10, s. 2(1).

3. The Licensee failed to protect resident #032, #043, and #047 and from abuse by co-residents #044 and #045.

In accordance with Ontario Regulation 79/10, s. 2 (1) physical abuse is defined as "the use of physical force by a resident that causes injury to another resident".

1. On an identified date in 2016, resident #044 had an altercation with resident #043. As a result of this altercation resident #044 sustained an injury. A few days later, resident #044 and resident #043 engaged in an altercation. As a result of this second altercation resident #043 sustained an injury that required transfer and treatment in the hospital.
As per interview with the Assistant Director of Care (ADOC) on January 17, 2018, staff were aware that resident #044 posed a risk to residents and had previous altercations with co-residents. The licensee failed to ensure that the resident was protected from abuse when resident #043 was injured as a result of an altercation with resident #044.

2. On an identified date in 2016, resident #045 was involved in an altercation with resident #047. As a result of this altercation resident #047 sustained an injury. As per interview with the registered staff #106 on January 23, 2018, staff were aware that resident #045 posed a risk to residents and had previous altercations with co-residents. The licensee failed to ensure that the resident was protected from abuse when resident #047 was injured as a result of an altercation with resident #045.

3. On an identified date in 2016, resident #045 as involved in an altercation with resident #032. As a result of this altercation resident #032 sustained injuries. As per interview with registered staff #106 on January 23, 2018, staff were aware that resident #045 posed a risk to residents and had previous altercations with co-residents. The licensee failed to ensure that the resident was protected from abuse when resident #032 was injured as a result of an altercation with resident #045.
(129)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

May 29, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 29 day of May 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PHYLLIS HILTZ-BONTJE - (A2)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Hamilton