Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_263524_0017	012658-16, 014198-16, 025529-16, 034204-16, 000655-17, 000950-17, 002220-17, 002230-17, 003051-17, 004408-17, 004545-17, 004950-17, 006537-17, 006945-17, 010717-17	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF GLENDALE CROSSING
3030 Singleton Avenue LONDON ON N6L 0B6

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

INA REYNOLDS (524), DEBRA CHURCHER (670), DONNA TIERNEY (569), DOROTHY GINTHER (568), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 19-23, 26-28, 2017.

The following complaint inspections were conducted:
Related to prevention of abuse and neglect:
Log # 014198-16
Log # 025529-16
Log # 000950-17
Log # 002230-17
Log # 004545-17
Log # 004950-17
Log # 010717-17
Related to infection control:
Log # 000655-17
Related to plan of care:
Log # 012658-16
Log # 002220-17
Log # 003051-17
Log # 004408-17
Log # 006537-17
Log # 006945-17
Related to falls prevention:
Log # 034204-16

During the course of the inspection, the inspector(s) spoke with the General Manager, the Director of Care, the Acting Director of Care, the Director of Food Services, the Director of Environmental Services, the Assistant Director of Food Services, one Corporate Nursing Consultant, two Neighbourhood Coordinators, two Resident Assessment Instrument Coordinators, one Physician, one Kinesiologist, one Registered Dietitian, the Activity Director, one Registered Nurse, 10 Registered Practical Nurses, 20 Personal Support Workers, one Scheduling Clerk, one Housekeeping Aide, family members and residents.

During the course of the inspection, the inspector(s) also observed residents and the care provided to them, resident and staff interactions, meal and snack service, resident rooms, medication administration, infection prevention and control practices, reviewed medical records and plans of care for identified residents, postings of required information, complaint records, minutes of meetings related to the inspection, staff training and education records, reviewed relevant policies and procedures of the home and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

This inspection was initiated as a result of complaint related to infection control practices. The inspector noted an infection control precaution sign on an identified resident's bedroom door. A Registered Practical Nurse (RPN) stated that they did not know why the precaution sign was on the door. The inspector and RPN reviewed the resident's chart and were unable to determine the purpose of the precautions. The RPN acknowledged that there was no documentation in the care plan or the chart to support the infection control precaution sign. RPN stated that they were not aware of an infectious process requiring the specific precautions. The inspector and RPN reviewed the resident's laboratory results which showed an identified result. The RPN stated that was probably the reason for the precautions and also stated that they were not sure.

A Personal Support Worker (PSW) stated they did not know why there was an infection control precaution sign on the resident's door. They further stated they would find the information in the care plan.

A Neighbourhood Coordinator (NC) stated that any interventions for infection control should be in the care plan with the interventions and reasons why the interventions were required. The NC later acknowledged that they had investigated and there were reasons identified why the interventions were required. The Director of Care (DOC) stated that the expectation of the home was that any infection control precautions should be included in the care plan and would include what precautions were to be utilized as well as the purpose of the precautions. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

This inspection was initiated as a result of a complaint related to failure to follow the care requested by the resident's substitute decision maker (SDM). The complainant stated that they had requested that an identified resident be tub bathed and not showered due to adverse reactions to showering. Resident's care plan stated that the "resident prefers a shower over a bath".

A Personal Support Worker (PSW) stated that they were not aware of any preference the resident or SDM had for bathing and that they had been completing showers for the resident with occasional tub baths.

A Neighbourhood Coordinator (NC) stated that they recalled a conversation with the SDM related to requesting a tub bath and not a shower. The NC acknowledged that it would be the expectation of the home that this preference should have been in the care plan and acknowledged that the care plan contradicts what the SDM had requested. The Director of Care (DOC) stated that it was the expectation of the home that the resident's plan of care would be reflective of the resident's preferences. [s. 6. (2)]

3. The licensee failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care.

This inspection was initiated as a result of a complaint related to allegations of improper care during an outbreak and a complaint which alleged improper management of an outbreak and insufficient supplies (PPE) being available during the outbreak.

a) The home went into an outbreak during an identified period.

An identified resident was line listed on a specific date, with symptoms of illness. The resident's care plan for a specific date, included that the resident required a minimum amount of millilitres (ml) of fluids daily, with a fluid goal identified in ml per kilogram (kg) of body weight. For the resident's identified kg of body weight, a daily fluid goal was determined. The plan of care documented the intervention of providing and encouraging intake of adequate kilo calories (kcal), protein and fluids at meals and snacks throughout the day; and, to record and review intake at meals and snacks on the nutrition and hydration flow sheets.

Review of the Nutrition and Hydration Flow sheet for a particular month for the resident showed that on multiple days, blanks were left in the documentation related to the resident's food and fluid intake. On multiple days the fluid intake documented was also well below the daily fluid goal.

Another identified resident was line listed on a specific date, with symptoms of illness. Review of this resident's plan of care for a specific date, included that the resident required a minimum amount of millilitres (ml) of fluids daily, with a fluid goal identified in ml per kilogram (kg) of body weight. For the resident's identified kg of body weight, a daily fluid goal was determined. The plan of care documented the interventions of providing a specific diet, texture and fluids; providing and encouraging intake of adequate kcal, protein and fluids at meals and snacks throughout the day; and, to record and review intake at meals and snacks on the nutrition and hydration flow sheets.

Review of the Nutrition and Hydration Flow sheet for a particular month for this resident showed that on numerous days, blanks were left in the documentation related to the resident's food and fluid intake.

The licensee's policy titled "Nutrition and Hydration - GC", Tab 07-24, not dated, documented that "the PCAs (Personal Care Aide) will complete the Nutrition and Hydration Flow Sheet in the dining room immediately following each resident meal to accurately record the amount of food and fluids consumed by each resident. The PCA will initial completion of the Nutrition and Hydration Flow Sheet. At the end of each shift, the RN/RPN will ensure the Nutrition and Hydration binder has been completed. Any incomplete Nutrition and Hydration Flow Sheets will result in the PCA being asked to return and complete the flow sheets".

In an interview, the General Manager (GM) stated that it was the Personal Support

Worker's (PSW) responsibility to complete the documentation and the Resident Assessment Instrument Coordinator and Registered Staff were responsible to ensure this was done.

b) The Resident Assessment Instrument (RAI) assessment completed for a specific date, showed that an identified resident was incontinent. A quarterly bowel and bladder assessment completed in a specific month, documented identification and specific treatments related to the resident's diagnosis. A review the resident's care plan for a specific month, from GoldCare showed specific interventions and tasks for a personal care need.

A review of the Medication Administration record (MAR) and Treatment Administration (TAR) was completed for a two month period. The MAR showed evidence that staff did not always administer the resident's medication and document its administration. The TAR showed evidence that staff did not always complete the tasks required and document the completion of the tasks.

On June 21, 2017, in interviews with the General Manager (GM) and Corporate Nursing (CNC) Consultant, they stated that the expectation was that staff administer the medication and document its administration. They stated they had changed their eMAR system from catalyst to paper and then back to eMAR with Point Click Care. They observed the MARs for the identified period, and the CNC acknowledged that staff in the home had changed and they were unable to determine if the medication was administered or not, but the expectation was that staff document the administration of the medication or note as to why it was not administered.

The GM and CNC observed the TAR for the identified time frame. They acknowledged that the TAR documentation was incomplete for a specific treatment. The CNC stated that they were unable to say if the tasks had been completed. The expectation was that staff were to have completed the tasks and document the completion of the tasks.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years as it was previously issued as a Voluntary Plan of Correction on January 31, 2017 under Inspection #2017_538144_0009 and July 27, 2016 under Inspection #2016_457630_0029, a Compliance Order #002 on November 24, 2015 under Inspection #2015_183128_0023 and a Voluntary Plan of Correction on September 9, 2015 under Inspection #2015_217137_0040. [s. 6. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; and, to ensure that the following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This inspection was initiated as a result of a complaint alleging resident to resident abuse and two Critical Incident System (CIS) reports submitted by the home related to resident to resident abuse.

Review of an identified resident's clinical record showed numerous incidents of responsive behaviour towards other residents between an identified period of time.

The home's policy titled "Prevention of Abuse and Neglect" Tab 04-06, not dated, stated Schlegel Villages had a zero tolerance with respect to abuse of any kind, including physical, sexual, emotional, verbal, financial and neglect from any person.

A Registered Practical Nurse (RPN) and a member of the Personal Expressions Response Team (PERT) stated that a number of interventions were in place for the resident in regards to keeping all residents safe, including checking on the resident. The RPN acknowledged that there was a different resident targeted for each incident. They stated that they were keeping all of the residents safe by checking at a range of time intervals. The RPN further stated that they felt these interventions were effective and also stated that they did not feel that there was a high risk in this situation. The RPN acknowledged that the range of time interval checks were not documented.

The plan of care for the resident stated, "Team to wear pager on them". The inspector attended the unit on a specific date, and requested to see the pager. The PSW came from the dining room and removed the pager from the drawer. The PSW acknowledged that staff generally left the pager in the drawer and also acknowledged that they could not hear the pager in all areas of the unit.

The Neighbourhood Coordinator (NC) stated that the staff were to check on the resident regularly, however, other than the PERT suggestion of checking the resident at periodic intervals, there was no direction to staff regarding the frequency of monitoring the resident. The NC acknowledged that a specific trigger that had been identified for this resident and acknowledged that there were no interventions put into place to manage this trigger. The NC further shared that there was significant risk related to this resident's responsive behaviours. The NC shared that the home had not implemented any one to one staffing for the resident and that there was significant potential and high risk for this resident to re-offend.

The licensee had failed to ensure that residents were protected from abuse by anyone.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years as it was previously issued as a Voluntary Plan of Correction on January 31, 2017 under Inspection #2017_538144_0009, a Compliance Order #004 on May 12, 2016 under Inspection #2016_262523_0016 and a Voluntary Plan of Correction on October 6, 2015 under Inspection #2015_262523_0026. [s. 19. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

This inspection was initiated as a result of a complaint alleging resident to resident abuse and a corresponding Critical Incident System (CIS) report submitted by the home related to resident to resident abuse. Review of a resident's clinical record stated that the reported alleged incident was documented in the clinical record on a specific date. Review of the submitted CIS report stated that the CIS report was submitted at a later date.

The home's policy titled "Investigation Process for Suspected Resident to Resident Abuse" Tab 04-06A, not dated, stated that, "if Abuse Algorithm determines need to report to the Ministry of Health and Long Term Care, immediately initiate and submit the on-line Critical Incident System identifying as a mandatory report or if after hours or a statutory holiday, contact the after hours mandatory reporting line".

The Neighbourhood Coordinator (NC) and Corporate Nurse Consultant (CNC) acknowledged the alleged incident occurred on a specific date, and was not reported until a later date. The NC and CNC stated that the incident should have been reported immediately.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years as it was previously issued as Compliance Order #005 on May 12, 2016 under Inspection #2016_262523_0016 and a Voluntary Plan of Correction on October 6, 2015 under Inspection #2015_262523_0027. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This inspection was initiated as a result of a complaint received by the Ministry of Health and Long-Term Care on a specific date, related to the home not managing and identified resident's increased pain symptoms.

During an interview on a specific date, a Registered Nurse shared that pain assessments for residents were to be completed when they had chronic pain that was not being managed, when a physician changed a resident's pain medication or there was an increase or decrease in dosage, for new admissions and re-admissions, and at quarterly assessments if there was an increase in the resident's pain level and frequency.

The Minimum Data Set (MDS) assessments were reviewed for the resident. The MDS

assessment for an identified date, documented and identified the resident's pain frequency score and the intensity of pain score. The next MDS review assessment for a specific date, documented and identified that the resident had an increase in the pain frequency score and the intensity of the pain score.

The home's policy "Pain Management Program" Tab 04-48 stated that the registered team would complete and document a pain assessment when the MDS pain score was two or more.

After review of their clinical record, no documented evidence was found that any pain assessments were completed for the resident.

The Resident had an order for pain medication to be given PRN (as needed) for pain. The order date was on a specific date. Review of the resident's Medication Administration Record (MAR) for a specific month, documented they received the PRN medication on multiple occasions. The MAR for the following month, documented that they received more PRN medication on numerous occasions which demonstrated the resident required an increase in pain medication from the previous month.

During interviews with the RN and Corporate Nurse Consultant on a specific date, both acknowledged that a pain assessment was not completed for this resident when the resident showed an increase in their pain frequency and intensity.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal harm/risk. The home had unrelated non-compliance in the last three years. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated and resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.

The home's policy titled "Resident/Family Concerns" Tab 11-21, not dated, documented that:
-"If a family member or resident expresses a concern to a team member, the team member will notify the Neighbourhood Coordinator (NC) or designate in writing by way of

an incident report form. The NC will contact the family member or resident on the same day to clarify the concern and acknowledge that the concern had been received.
-The NC will immediately investigate the basis of the concern and possible solutions.
-The NC will contact the family member or resident directly within 5 working days of commencement of the investigation. Where the complaint alleges harm or risk of harm, the investigation shall be commenced immediately to ensure safety.
-If the concern is of a significant nature, the General Manager will be involved in the investigation and subsequent discussion with the family or resident.
-The NC will carefully document all discussions with the family members and results of investigations using the attached form. The General Manager will review the form, place one copy in the resident's file, and one copy in the resident concerns binder in the General Manager's office".

During a specific month, the home went into an outbreak. The line listing showed that on a specific date, an identified resident had symptoms related to the outbreak and was added to the line listing for the outbreak.

On a specific date and time, following an assessment, progress notes indicated that the resident required medical attention. Progress note documentation dated on a specific date and time, showed staff were asked to inquire about the care given to the resident and the handling of the outbreak.

In interviews completed on a specific date, a Neighbourhood Coordinator (NC) stated that they had received a call from the resident's family who was upset and was yelling. The family member alleged the resident received improper care during the outbreak and the home did not clean. The NC stated they did not complete a complaint form. The NC stated they understood the concern was related to the cleanliness of the home during the outbreak and not related to care; if the concern received was specific to the resident then a form would have to be completed. The NC did not recall if they filled out any form for the area not being cleaned or if they spoke to environmental services about this concern.

The General Manager (GM) on a specific date, acknowledged awareness of the complaint from the resident's family alleging improper care and handling of the outbreak. The GM stated they would have considered this as a concern of a significant nature if they had seen a concern form. They stated sometimes the home had families who would have a discussion with the NC and neither family or staff thought it would need to go further. The GM stated the expectation was that they should have received a concern form especially if a progress note was made related to the allegation. The GM stated

they knew that the family were unhappy and there were other families on the identified unit that were not happy at that time. The GM further stated that from everything they had read at the time, they did not get a red flag from this. The GM stated the expectation was that this would be fully investigated.

The licensee had failed to ensure that a verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated and resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made by the complainant.

The home had received two concerns related to improper care and management of an outbreak which began during a specific month.

The home's policy titled "Resident/Family Concerns" Tab 11-21, undated, documented that:
-"If a family member or resident expresses a concern to a team member, the team member will notify the Neighbourhood Coordinator (NC) or designate in writing by way of an incident report form. The NC will contact the family member or resident on the same day to clarify the concern and acknowledge that the concern had been received.
-The NC will immediately investigate the basis of the concern and possible solutions.
-The NC will contact the family member or resident directly within 5 working days of commencement of the investigation. Where the complaint alleges harm or risk of harm, the investigation shall be commenced immediately to ensure safety.
-If the concern is of a significant nature, the General Manager will be involved in the investigation and subsequent discussion with the family or resident.
-The NC will carefully document all discussions with the family members and results of

investigations using the attached form. The General Manager will review the form, place one copy in the resident's file, and one copy in the resident concerns binder in the General Manager's office".

During a specific month, the home went into an outbreak. The line listing showed on a specific date, an identified resident had symptoms and was added to the line listing for the outbreak.

On a specific date and time, following an assessment, progress notes indicated that the resident required medical attention.

In interviews completed on a specific date with a Neighbourhood Coordinator (NC), it was stated that they had received a call from the resident's family who was upset and was yelling. The family alleged improper care of the resident during the outbreak and the home did not clean. The NC stated they did not complete a complaint form. The NC stated they understood the concern was related to the cleanliness of the home during the outbreak and not related to care; if the concern received was specific to the resident then a form would have to be completed. The NC did not recall if they filled out any form for the area not being cleaned or if they spoke to environmental services about this concern.

In interviews completed on two specific dates, a Registered Practical Nurse (RPN) stated that the resident's family were concerned about things that had happened previously and expressed a particular concern about cleanliness and they expressed concern about other residents. The RPN could not recall if they passed things on and stated the concerns were brought forward at the end of the day. The RPN stated the expectation would be to do a progress note and follow up with the NC or Director of Care about the concern.

The General Manager (GM) acknowledged awareness of the complaint from the resident's family alleging improper care and handling of the outbreak. They stated sometimes the home had families who would have a discussion with the NC and neither family or staff thought it would need to go further. The GM acknowledged that there was no resident concern form which documented the complaint.

The licensee had failed to ensure that for every verbal complaint made, the corresponding documentation was completed.

The scope of this area of non-compliance was isolated and the severity was determined

to be potential for risk. The home had related non-compliance in the last three years as it was previously issued as Compliance Order #003 on August 4, 2016 under Inspection #2016_457630_0029, Compliance Order #011 on May 12, 2016 under Inspection #2016_262523_0019, a Voluntary Plan of Correction on November 24, 2015 under Inspection #2015_183128_0023 and a Written Notification on September 9, 2015 under Inspection #2015_217137_0040. [s. 101. (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 ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, and a response is provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately; and, that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or

herself unless the administration was approved by the prescriber in consultation with the resident.

The home's policy titled "Administration of Medications" Tab 05-03, review date December 12, 2016, documented to "never leave medication for the resident to administer to him/herself unless there is a Physician's order allowing that person to self-medicate or is listed in their care plan" and, to "remain with the resident until the medication has been swallowed, unless otherwise indicated in the resident's plan of care".

During observations completed on a specific date, an identified resident was seated at a table with a co-resident in the dining room. There was a white substance in a medication cup left in front of the resident; it was half full of white liquid. No staff were in attendance in the dining room. On a specific date, another resident was observed with a plastic medication cup with clear liquid in front of them while seated at a table in the dining room. Two other residents were seated at that table. The RPN was observed administering medications to other residents at the time.

A review of the physician's orders for the two residents did not show a physician's order that the residents could self-administer medications. A review of the care plan for both residents did not show documented evidence that the residents could self-administer medications.

In interviews on two specific dates, a Registered Practical Nurse (RPN) stated that the resident usually never drinks the whole thing. The RPN stated what the medication was and that the expectation was that the resident takes the medication and that they were to make sure it was administered. The RPN acknowledged that they had administered the medication that morning to the other resident and identified the medication. The RPN stated that the expectation was that the resident be observed to take their medications.

The General Manager stated that the expectation was that when residents were administered medications, staff were to observe that the medication was taken. If the resident refused or did not take all of the medication, it was to be thrown away.

The licensee had failed to ensure that no resident administers a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years as it was previously issued as a Voluntary Plan of Correction on September 21, 2016 under Inspection #2016_277538_0025, on March 14, 2016 under Inspection #2016_262523_0026 and on November 24, 2015 under Inspection #2015_183128_0023. [s. 131. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control interdisciplinary team meet at least quarterly.

Review of the minutes from the Infection Prevention and Control (IPAC) meetings did not show documented evidence of the team meeting at least quarterly. Dates of the meetings as per the IPAC minutes showed a meeting was held March 17, 2016; June 8, 2016, August 25, 2016, November 25, 2016 and February 1, 2017. The minutes dated November 25, 2016 and February 1, 2017, appeared to be the same. There were no other IPAC minutes for 2017.

In interviews completed June 28, 2017 and July 12, 2017, a Neighbourhood Coordinator (NC) stated there was no current IPAC lead at the home. The NC reviewed the minutes of the meetings dated November 25, 2016 and February 1, 2017, and acknowledged they appeared the same.

In an interview with the General Manager (GM), they stated that they did not attend the IPAC meetings. The GM stated they had been at the home since September 2016 and to the best of their knowledge only two IPAC meetings took place on November 25, 2016 and February 1, 2017; and they were not very dense meetings.

The licensee had failed to ensure that the Infection Prevention and Control interdisciplinary team meet at least quarterly. [s. 229. (2) (b)]

2. The licensee has failed to ensure that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During the inspection the home was unable to provide documented evidence that the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

In an interview on June 28, 2017, the NC stated there was no record of any infection prevention and control evaluation. The NC stated they had checked with corporate office and there was no evaluation.

In an interview with the GM on July 12, 2017, they stated that in mid May 2017, a meeting was held to discuss programs as the accuracy and documentation had fallen off and that they were looking at it from a quality assurance perspective to determine what this documentation should look like.

The licensee had failed to ensure the Infection Prevention and Control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 229. (2) (d)]

3. The licensee has failed to ensure that on every shift, the symptoms of residents' infections are recorded and immediate action was taken as required.

Review of the daily surveillance documentation during an identified outbreak for a particular unit showed that for a specific time frame, daily surveillance documentation was recorded on each shift for multiple line listed residents. On an identified date, there was no evidence of daily surveillance recorded. On the following day, numerous residents were documented on an a shift with one identified symptom. There was no further documentation recorded on the daily infection control surveillance sheets.

In review of the 2016 Infection Control and Prevention (ICP) plan for the home, documentation related to Surveillance and Monitoring stated:
- "use of daily surveillance sheets by team leaders in each neighbourhood, ensure team leaders are documenting on every shift.
- daily surveillance sheets had been revised September 2015, UTI and URI tracking forms had been added to the Daily Surveillance to capture specific data.
- ICP to collect data from Daily surveillance sheets for monthly infection audits. Data is collected and is then analyzed for any trends or spikes with regard to infections to look at possible root causes and develop action plans to minimize the risk or decrease rates of certain infections".

In interviews on a specific date, the NC stated that the Assistant Director of Care (ADOC) was to review the daily surveillance. They would come around to the units to collect the data. The requirement was that the daily surveillance sheet was to be filled out at each shift. When shown documentation for this outbreak the NC acknowledged that the form was incomplete. The NC was unable to locate documentation related to the daily surveillance related to this outbreak. The NC stated that staff should record the immediate action taken in the resident's progress note.

In an interview, the GM stated it was up to the Registered staff and ADOC to complete daily surveillance for infections. Staff monitor signs and symptoms, look at fluid intake and it would be expected to be done once per shift and documented. When asked about use of the daily surveillance documents for infections at the home and about the blanks left in the daily surveillance documents which were provided for the identified month of the outbreak, the GM stated it was the expectation that staff use the daily surveillance form to document signs and symptoms of infections in residents. [s. 229. (5) (b)]

4. The licensee has failed to ensure that the information gathered on every shift about the residents' infections was analyzed daily to detect the presence of infection and

reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

Review of documentation provided from the Infection Prevention and Control binder did not show documentation that the information gathered on every shift about the residents’ infections was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

In an interview with the GM, they stated that if this was not found when the inspector was on site it would be part of the missing paper work from the last team.

The licensee had failed to ensure that the information gathered on every shift about the residents' infections was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years as it was previously issued as a Voluntary Plan of Correction on January 31, 2017 under Inspection #2017_538144_0009, a Compliance Order on August 4, 2016 under Inspection #2016_457630_0029 and May 12, 2016 under Inspection #2016_262523_0016. [s. 229. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control interdisciplinary team meet at least quarterly; that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; that staff on every shift record symptoms of infection in residents and take immediate action as required; and, that the information that is gathered on every shift about the residents' infections is analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks, 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 :

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

a) The home's policy titled "Head Injury Routine" Tab 04-37, not dated, documented that non-PointClickCare villages would use the Neurological/Head Injury Vital Signs Record form with all sections being completed for the following time periods: Every 15 minutes, once if the resident was stable and no abnormal changes; every 30 minutes for two hours if the resident was stable and no abnormal changes; every one hour for two hours

if the resident was stable and no abnormal changes; every four hours for 24 hours if the resident was stable and no abnormal changes; and, every shift for two days if the resident was stable and no abnormal changes.

Review of progress notes and the Falls Incident report for a specific date, for an identified resident showed that the resident had an unwitnessed fall when trying to self transfer. Documentation indicated the resident was assessed and did not have an injury.

A Head Injury Routine (HIR) was initiated on a specific date and time, however entries on the assessment between specific identified hours, it was documented that the resident was sleeping and their level of consciousness was documented as drowsy.

In interviews completed with the Corporate Nursing Consultant (CNC) on June 21, 2017, they stated that the expectation was that staff were to wake the resident to assess them. The CNC stated that staff did not follow the head injury routine.

b) The home's policy titled "Managing an Enteric Outbreak" Tab 04-03, not dated, documented that the team members' immediate response to the outbreak was to isolate any residents with new acute enteric symptoms with a contact precaution sign and recommended personal protected equipment (PPE). "All residents will be isolated to their rooms until they are symptom-free for 48 hours, or as directed by Public Health. PPE should be put into place at this time. Ensure contact precaution signage is in place on the ill resident's door. Recommended PPE to be available for team members and visitors. Alcohol-based hand rub will be available and visitors will be encouraged to clean their hands". The policy included that the charge nurse was responsible to post isolation signs on resident room doors, assist in maintaining the line listing and supervise isolation procedures and ensure that adequate supplies were available.

An identified outbreak was declared at the home on a specific date, on a specified unit. Documentation from the Public Health unit related to the outbreak control measures indicated that surveillance and contact precautions were to be implemented including line listing of staff and residents, hand hygiene, mask/eye protection, gowns and gloves; effective on a specific date.

In an interview with an identified resident's Power of Attorney (POA), they stated that the resident had exhibited symptoms of the outbreak the morning of a specific date, and no PPE was present and no signage was on the resident's door. They stated that there was insufficient PPE to go around and that staff told them they could not put up signage until

a PPE cart was available. The POA stated a cart was not made available until 1830 hours.

Staff interviews were completed on two specific dates. The RPN identified that they had worked when the outbreak was declared on the specific unit. Two RPNs stated that they did not have sufficient PPE supplies for every resident who was line listed on their unit; they reported this to the Assistant Director of Care (ADOC). The RPN stated that the line listing had not been kept up to date and PSWs were not sure which residents were symptomatic during the outbreak. Both RPNs stated staff had to go to other resident rooms to access supplies or other units to get the required PPE supplies. A key was required to the "cage" for PPE supplies and nursing did not have access to this. The RPN said signage was present for affected residents, but it was not put up immediately.

In an interview on June 28, 2017, a Neighbourhood Coordinator(NC) stated that as soon as a resident exhibited two symptoms there should be PPE available as soon as a resident exhibited two symptoms. The NC stated they had difficulty getting staff to comply with using all of the PPE and they had huddles with staff to discuss this.

c) The home's policy titled "Administration of Medications" Tab 05-03, review date December 12, 2016, documented the following:
- "When a medication is declined, or cannot be administered, it is to be destroyed and documented as such.
- Never leave medication for the resident to administer him/herself unless there is a Physician's order allowing that person to self-medicate or is listed in their care plan.
- Remain with the resident until the medication has been swallowed, unless otherwise indicated in the resident's plan of care".

During observations completed on a specific date and unit, an identified resident was observed seated at the dining room table with a co-resident. The resident had a plastic medication cup half full of white liquid in front of them. The resident appeared to be dozing. There were no staff present in the dining room.

A review of the resident's Medication Administration Record (MAR) on Point Click Care, showed that at a specific hour on an identified date, the resident was to be administered a medication. This medication had been signed off as given by the Registered Practical Nurse (RPN). A review of the resident's care plan on Point Click Care did not show any documentation related to leaving medication for the resident to administer independently. A review of physician's orders for the resident did not show evidence of an order for self-

administration of medication.

On a specific date and unit, a plastic medication cup with clear liquid was observed to be in front of another identified resident, who was at the dining room table with two other residents. There were two Personal Support workers in the dining room assisting other residents with eating. The RPN was present and administering medications to other residents.

A review of resident's MAR on Point Click Care, showed that at a specific hour on an identified date, the resident was to be administered a medication and it was documented as administered. This medication had been signed off as given by the Registered Practical Nurse (RPN). A review of resident's care plan on Point Click Care did not show any documentation related to leaving medication for the resident to administer independently. A review of physician's orders for this resident did not show evidence of an order for self-administration of medication.

In interviews completed on two specific dates, the RPN identified the medication left at the table for the resident. They stated that the expectation for medication administration was that they administered the medication and the resident would take it. When asked if there was a requirement for them to stay and observe that the medication was taken, the RPN stated they had stayed, however the inspector had observed the resident left alone at the dining table with the medication in front of them. The RPN also stated that the expectation was that a PSW stayed in the dining room or if the RPN was done the medication passes then they would stay.

Another RPN identified the medication left in front of another identified resident. This RPN stated that the expectation was that the resident be observed to take their medications and acknowledged if the resident did not take all of the medication, they would thrown the medication cup out.

The General Manager (GM) and Neighbourhood Coordinator (NC) stated that the expectation was that when residents were administered medications staff were to observe that the medication was taken. If the resident refused or did not take all of the medication, it was to be thrown away.

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

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had related non-compliance in the last three years as it was previously issued as a Written Notification on May 9, 2016 under Inspection #2016_262523_0019, a Compliance Order #006 on August 26, 2016 under Inspection #2016_262523_0016, and a Voluntary Plan of Correction on November 24, 2015 under Inspection #2015_183128_0023 and on October 6, 2015 under Inspection #2015_262523_0026. [s. 8. (1) (a),s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) a care conference of the interdisciplinary team providing a resident's care was held at least annually to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker; (b) the resident, their substitute decision-maker, and any other person that either of them may direct was invited to participate in these care conferences; and (c) a record was kept of the date, the participants, and the results of the conferences.

This inspection was initiated as a result of a complaint alleging that the home did not hold an annual care conference that included the substitute decision-maker (SDM) in the development and implementation of the resident's plan of care. The complainant acknowledged that there was no care conference held for a specific calendar year. The inspector was unable to locate any documentation related to an annual care conference for the specific calendar year.

A Neighbourhood Coordinator (NC) acknowledged that there was no documentation for a care conference in the identified year. The NC stated that they did not recall completing a care conference with this resident and the SDM in that year. They further acknowledged that if there was no documentation related to the annual care conference, then it did not happen. Acting Director of Care (DOC) stated that it was the expectation of the home that an annual care conference was held for all residents and that all care conferences were documented in the electronic record.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 27. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

This inspection was initiated as a result of complaint alleging resident to resident abuse and a corresponding Critical Incident System (CIS) report submitted by the home related to resident to resident abuse.

Review of an identified resident's clinical record stated that the reported alleged incident was documented in the clinical record on a specific date, and the substitute decision-maker (SDM) notification was documented four days later. Review of the submitted CIS report stated that the CI date was on a specific date, and the date of submission/SDM notification was four days later.

The home's policy titled "Investigation Process for Suspected Resident to Resident Abuse" Tab 04-06A, not dated, stated that the "Charge Nurse or designate to notify the resident's substitute decision-maker, if any, and any other person specified by the resident".

The Neighbourhood Coordinator (NC) acknowledged that the incident occurred on a specific date, and that it was not reported to the SDM until a later date. The NC and Corporate Nurse Consultant stated that the SDM should have been notified on the same specific date.

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had unrelated non-compliance in the last three years. [s. 97. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

This inspection was initiated as a result of a complaint alleging resident to resident abuse and a corresponding Critical Incident System (CIS) report submitted by the home related to resident to resident abuse. Review of the submitted CIS report stated that the police were not contacted.

The home's policy titled" Investigation Process for Suspected Resident to Resident Abuse" Tab 04-06A, not dated, stated that "any alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence will be reported to the police by the charge nurse or designate immediately".

The Neighbourhood Coordinator (NC) shared that the Director of Care declined police notification of the incident. The NC acknowledged that the home did not contact the police but should have notified them. The Corporate Nurse Consultant acknowledged that the home should have notified the police.

The scope of this area of non-compliance was isolated and the severity was determined to be minimal risk. The home had unrelated non-compliance in the last three years. [s. 98.]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 13th day of October, 2017

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

Original report signed by the inspector.