Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2018	2017_607523_0033	007403-17, 011823-17, 014514-17, 014821-17, 015976-17, 017624-17, 021790-17, 022211-17, 023214-17, 024872-17, 025974-17	Critical Incident System

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
108 Jensen Road LONDON ON N5V 5A4

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

ALI NASSER (523), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 14, 15, 16, 17, 20, 21, 22 and 23, 2017.

PLEASE NOTE: A Written Notification related to O. Reg. 79/10, r. 8 (1) b identified in

concurrent inspection #2017_607523_0032 (Log #016143-17, 018214-17) will be issued in this report.

This inspection was completed for the following Critical Incidents as follows:
Log #014514-17 / CIS #3047-000020-17 related to alleged resident to resident abuse.

Log #017624-17 / CIS #3047-000027-17 related to a resident's fall.
Log #021790-17 / CIS #3047-000032-17 related to a resident's fall.
Log #023214-17 / CIS #3047-000038-17 related to a resident's transfer.
Log #024872-17 / CIS #3047-000044-17 related to alleged resident to resident abuse.
Log #025974-17 / CIS #3047-000049-17 related to alleged resident's neglect.
Log #011823-17 / CIS #3047-000018-17 related to alleged resident to resident abuse.
Log #014821-17 / CIS #3047-000021-17 related to alleged staff to resident abuse.
Log #015976-17 / CIS #3047-000024-17 related to alleged resident to resident abuse.
Log #022211-17 / CIS #3047-000031-17 related to a missing controlled substance.
Log #027065-17 / CIS #3047-000055-17 related to misappropriation of medications.
Log #007403-17 / SAC Report #15285 related to alleged staff to resident abuse.

The following intakes were completed concurrently with this inspection as follows:
Log #023421-17 a Follow up inspection related to screening measures.
Log #016143-17 / IL-51922-LO related to a resident's care concerns.
Log #018214-17 / IL-52257-LO related to a resident's care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Dietary Services Manager, Maintenance Manager, Resident Care Coordinator, Physiotherapist, Physician, 13 Registered staff members, 16 Personal Support Workers (PSW), two family members and 15 residents.

The inspector(s) also observed residents and resident staff interactions, reviewed clinical records for identified residents and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

8 WN(s)
3 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept relating to each evaluation under paragraph 3 that included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Ontario Regulation 79/10 s. 48 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain."

A review of the annual evaluation of the Skin and Wound Program, Falls Management Program, Pain Management Program and Continence Care and Bowel Management Program showed that there was no record of the names of the persons who participated in the evaluation, and no record of a summary of the changes made and the date that those changes were implemented.

On a certain date the Administrator and the Director of Care (DOC) said in an interview that the evaluation of the above specified programs were completed before they assumed their current roles in the home. They said that the annual evaluations had no record of the names of the persons who participated in the evaluation, and no record of a summary of the changes made and the date that those changes were implemented.

The Administrator and the DOC said that they planned to complete program reviews and annual evaluations of the required programs with the interdisciplinary teams in the near future.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to resident. The scope of the non-compliance was isolated, this area of non-compliance was not previously issued. [s. 30. (1) 4.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 the matters referred to in subsection (1) were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; at least annually, the matters referred to in subsection (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and a written record was kept relating to each evaluation under clause (b) that included 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.

Ontario Regulation 79/10 s. 53. (1) states, " Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required."

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date which identified an “incident of alleged staff to resident abuse/neglect.” This report stated that a Registered Nurse (RN) was called to a resident's room by a Personal Support Worker (PSW), the RN found the resident's call bell was pulled out and something was plugged in instead. The call bell was placed on the bed side table.

On a certain date a PSW said: " the resident had lots of responsive behaviours, they yelled out and used the call bell a lot" The PSW said that the resident was referred to Behavioural Supports Ontario (BSO), they had completed a certain assessemnt for the resident but they were not informed about the results of the assessment or the interventions that were put in place.

A review of the home’s policy titled "Responsive Behaviours Management", Index: BM-L-05, last revised September 2017, showed under procedure that upon occurrence of an episode of responsive behaviour a registered staff would initiate a post-behavioural huddle to review the behaviour in conjunction with the care team. The purpose of the huddle was to review the behaviour exhibited, strategize to minimize or eliminate the recurrence of the behaviour and to determine effectiveness of current strategies and to ensure that all required information had been collected and documented.

A clinical record review for the resident showed that a certain assessment was completed on the resident, resident had not been seen since and was discharged by BSO.

In an interview a RPN said that they did not complete a post-behavioural huddle when a resident exhibited responsive behaviours.

In an interview a RPN said that a certain assessment was not always being done in the home and that the post-behavioural huddle was not being done in the home.

On a certain date a BSO-PSW said in an interview that part of the screening protocols to identify triggers and set up interventions was for staff to complete the assessment charting and the post-behavioural huddle.

A clinical record review for the resident with BSO-PSW showed the following: the assessment charting completed at a specific period of time was missing 107 out of 371 entries and there was no post-behavioural huddle completed for the resident. The BSO-PSW said that staff almost never completed the assessment charting and sometimes it was not accurate. They said that the post-behavioural huddle was also not being completed when residents exhibited responsive behaviours.
The BSO-PSW said that they had no information as to why the resident was referred to BSO or what assessments were completed after the assessment charting was done. They said that they had been part of the BSO team for two years but they did not take part in any evaluation completed for the responsive behaviours program.

In an interview the Administrator and the DOC acknowledged the screening tools identified in the Responsive Behaviours Management policy and procedures were not fully or accurately being completed by the staff. They said that they were not sure if the annual evaluation of the responsive behaviour program was completed, they were not able to find a written record relating to the evaluation that included 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.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to resident. The scope of the non-compliance was widespread, this area of non-compliance was not previously issued. [s. 53. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, 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 identifying and implementing interventions.

A) The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date which identified an"incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status." This report stated that a resident had been "exhibiting behaviours at staff and was agitated" and that this resident had pushed another resident who had a fall that resulted in an injury. The report also stated that the resident "has a history of behaviours and staff were managing behaviours effectively and resident was not displaying agitated behaviours.

On a certain date a BSO PSW told Inspector that the resident had a history of responsive behaviours directed towards staff and other resident that was pushed down. The BSO PSW said the other resident tended to hover around the resident and then the resident would have a quick reaction and strike out at them. The BSO PSW said that they were aware that the other resident had a fall and that staff thought that the resident had pushed them. BSO PSW said that the BSO RPN has been responsible for the assessments and interventions for the residents in that area and therefore they were not sure what may have been done regarding resident's responsive behaviours. BSO PSW

said that the BSO RPN was not available to interview at the time of the inspection as they were on a leave from the home. BSO PSW said that the Resident Care Coordinator was the new temporary lead for the BSO program and had not been involved in the assessments or interventions within the program at the time of the incident between the residents.

On a certain date a BSO PSW told the Inspector that they had reviewed the clinical chart for the resident and found that these showed that the resident did have behaviours related to aggression towards another resident. BSO PSW said there had been a referral to the BSO team on a certain date related to physical aggression towards the other resident which resulted in a fall. This referral had been documented on the referral form as being followed-up by the BSO RPN. BSO PSW said that based on the documentation there was a BSO progress note that the BSO RPN had spent time with the resident and suggested pain monitoring but there was no documented assessment. BSO PSW said that usually they would assess a resident using specific assessments. BSO PSW said that there was no documented evidence that interventions were implemented for the resident at that time related to aggressive behaviours towards another resident. BSO PSW said there was another referral made to BSO on a certain date, which showed that the resident had struck another resident. They said that this referral form did not include a date or documentation to show that the BSO lead had addressed the referral and stated that assessment was initiated. BSO PSW said that the assessment's charting was initiated but was incomplete as staff had not documented the observed behaviours as required on the form. BSO PSW said there was no other observed assessment form or documentation of assessment regarding this referral in the progress notes or the BSO documentation. BSO PSW said that they had been off work at the time of the referral and was not involved in the assessment or development of interventions for the resident at that time.

On a certain date a PSW said they worked in the home on a casual basis and did provide care to the resident and the other resident. The PSW said that the resident was having some responsive behaviours towards staff but was not aware of any concerns with responsive behaviours that were directed towards other residents. PSW said that they knew the other resident tended to check on the resident regularly but did not think that the other resident had the tendency to go into the resident's room. The PSW said they would look in the plan of care to find out about responsive behaviours including the interventions that were in place.

On a certain date a RPN said that they were aware that the other resident had a fall and

that it was reported by them that the resident had pushed them. The RPN said that prior to the fall the other resident was independent with mobility and did not have a history of falls, but due to the fall they were sent to hospital for treatment. The RPN said that prior to this incident the resident had been known to be aggressive with the other resident as well as with staff. RPN said that the resident had a history of specific responsive behaviours or aggressive behaviours towards anyone. RPN said that they made adjustments in the resident's specific medications and added an as needed dose of a specific medication but otherwise the resident had no further changes in medications or changes in interventions related to these behaviours. When asked about the specific incident RPN said that the resident was aggressive towards the other resident but there was no injury at that time.

On a certain date a RPN said that they had been working at the time when the other resident had the fall and they had completed the post fall assessment. The RPN said the fall was not witnessed by staff and that the other resident was found on the floor and the resident was also in the same room at the time. RPN said that the other resident told the staff that the resident had pushed them. RPN said that prior to the fall the resident had some responsive behaviours towards the other resident as they would raise their voice or their fist at them and the staff would need to redirect the other resident away from the resident. RPN said that residents' observed or reported responsive behaviours were to be documented in PCC as a progress note. When asked how they would know if there were assessments and interventions in place for a resident related to responsive behaviours, RPN said they would look in the plan of care as well as the BSO binder at the desk. When asked about the assessment charting, RPN said that these were completed by the PSWs and RPNs during the shift and that the assessment charting was not always being completed within the home. Inspector reviewed the BSO referrals with RPN. They said that they had made referrals to BSO on two specific dates regarding the resident's responsive behaviours towards the other resident. RPN said they recalled that assessment charting had been initiated on one occasion, but otherwise could not recall assessments or interventions that had been implemented related to these referrals apart from redirecting the other resident away from the resident.

The clinical record review for the resident showed that the resident was agitated and other residents were complaining that resident was loud and physically aggressive sometimes towards staff and other residents. A BSO referral was completed on a certain date, there no documentation of an assessment or documentation regarding responsive behaviours towards the spouse.
- A physician progress note completed on a certain date which stated "agitation and

aggression triggered usually by care. Recently discharged from BSO as no current issues.
- A progress note completed on a certain date which stated "resident was on a certain assessment charting, tracking aggressive behaviours" and "BSO writer reviewed the charting today with findings that it was three quarters complete. From what was completed resident did not present any signs of aggression throughout the day or evening shifts."

The plan of care for the resident included a focus "altered behaviours related to behavioural and psychological symptoms due to a certain diagnosis as evidence by episodes of verbal and physical aggression, refusing care and being disruptive." The documentation showed this section of the plan of care was last revised earlier in the year and did not include the identification or interventions related to the responsive behaviours towards the other resident. The BSO written plan of care was dated as last revised recently and did not include the identification or interventions related to the responsive behaviours towards the other resident.

On a certain date the Administrator said they had been informed by staff of CIS report in which the resident was reported to have pushed another resident resulting in an injury. The Administrator said that it was the expectation in the home that when there was resident to resident altercations then there would be assessments completed and interventions implemented. Administrator said that they reviewed the documentation regarding the incidents that had occurred between the two residents and acknowledged that the resident's responsive behaviours had not been assessed and the plan of care had not been updated to identify the risk of physically responsive behaviours towards their spouse or include interventions to minimize the risk of these behaviours.

Based on these interviews and record review the home had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents. Staff and management in the home were aware of the potential risks, through information provided by other residents and staff observations, but interventions were not identified through the documented plan of care or consistently implemented.

B) The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date, which was identified as a potential resident to resident abuse. This report stated that on a certain date, a resident had "ongoing responsive behaviours since admission."

The home immediately notified the MOHLTC on a certain date of an alleged resident to resident abuse. The CIS report showed that staff witnessed the resident grabbed another resident.

On a certain date a RPN said that the resident had a history of specific responsive behaviours. The RPN said they were aware of an incident when the resident had touched another resident. When asked what interventions were in place for the resident's specific responsive behaviours, RPN said that the resident received medications for behaviours, staff were watching the resident closely and BSO was involved. RPN said the resident had difficulty in communication.

On a certain date a PSW said that the resident had a history of a "specific behaviours" and they thought these behaviours had mainly been directed towards staff. When asked if there were any interventions for the resident's behaviours they said that BSO would tell them suggestions on how to speak to this resident. When asked if there were any interventions for the resident regarding potential specific behaviours towards other residents, PSW said they could not think of other interventions and that sometimes the resident did not understand what staff were saying to them due to a difficulty in communication and specific medical condition.

A clinical record review for the resident showed that the resident had expressed responsive behaviours towards other residents, no documentation that that the RN or any management in the home had been notified of the incident. The communication techniques were not working, a referral was completed to the BSO program and the resident was assessed by the BSO team. The resident was assessed by an external resource team but there was no documentation for the responsive behaviours. The resident's behaviours continued to occur.
The clinical record included no documented assessments of the resident's specific responsive behaviours completed by registered staff in the home, the BSO team or external resources in 2016 or 2017.

The plan of care for the resident included a focus "altered behaviours related to cognitive decline." The focus did not identify that the resident had specific responsive behaviours directed towards other residents or include triggers for these behaviours. The plan of care did not include the identification or interventions related to the specific responsive behaviours towards other residents. The documentation showed this section of the plan of care was not revised between specific periods of time.

On a certain date the intervention section in the plan of care was updated to direct staff to "intervene as needed to protect the rights and safety of others. Approach/speak in calm manner. Divert attention. Remove from situation and take to another location as needed." No other interventions related to these responsive behaviors were added to the resident's plan of care between specific periods of time. There was no BSO written plan of care for the resident.

On a certain date a Behavioural Supports Ontario (BSO) PSW said that on a specific date BSO received a referral for the resident related to specific responsive behaviours. BSO PSW said they provided education to staff on a specific date regarding specific behaviours as the resident had been having these types of behaviours directed towards staff and residents. BSO PSW reviewed a specific assessment charting for the resident and indicated that there had been documentation of "specific behaviour" towards another resident on specific date and time but there were no other documented details and this assessment charting was incomplete. BSO PSW said that the BSO RPN had tried to make a referral to the Behavioural Response Team but was told that they did not accept referrals for a resident to see the psychiatrist or to review medications and BSO PSW was not sure what happened with the referral. BSO PSW reviewed the BSO documentation and assessments for the resident with Inspector and acknowledged that there were no assessments completed apart from the progress note BSO PSW had completed on a certain date. BSO PSW said that they were not responsible for updating the plan of care as that was the responsibility of the BSO RPN. BSO PSW acknowledged looking at the plan of care that there was no documented triggers or interventions related to the specific responsive behaviours towards other residents. BSO PSW said they had implemented specific interventions that staff were to use as an activity for the resident and acknowledged that this intervention was not referenced in the plan of care. BSO PSW said that there were changes to the resident's medications made when in hospital but otherwise no involvement in assessments by external resources.

On a certain date the DOC and the Administrator told the Inspector that they had been involved in investigating these critical incidents related to alleged abuse. When asked what interventions were in place for the resident's responsive behaviours prior to the incident, the Administrator said that they had tried to put interventions to keep the resident busy. The DOC said that there had been referrals to external resources but no one had been in to assess the resident prior to or after the specific incident.

During a follow-up interview on a certain date the Administrator told Inspector that they had reviewed the documentation for the resident. The Administrator said that based on

their review of BSO documentation and plan of care, there had not been triggers identified related to the resident's specific responsive behaviours or interventions in place to minimize risk of altercations with other residents. The Administrator said the plan of care and interventions were focused on behaviours towards staff versus other residents. The Administrator said that it was the expectation in the home that when there was risk of resident to resident altercations then there would need to be assessments completed and interventions implemented.

Based on these interviews and record review the home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents. Staff and management in the home were aware of the potential risks, through information provided by other residents and staff observations, but interventions were not identified through the documented plan of care or consistently implemented.

During the inspection this non-compliance was found to have the severity level of actual harm/risk. The scope of the non-compliance was a pattern, this area of non-compliance was not previously issued. [s. 54.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times and was on at all times.

The home submitted a CIS report to the MOHLTC on a certain date which identified an "incident of alleged staff to resident abuse/neglect." This report stated that a RN was called to a resident's room by a PSW, the RN found the resident's call bell pulled out and something was plugged in instead. The call bell was placed on the bed side table.

The resident said in an interview that one of the Personal Support Workers (PSW) pulled the call bell out of the wall. The resident said that they tried to call for help during the night but it was not working. The resident said that they needed help and were not able to get anyone because the call bell was not ringing.

The DOC said in an interview that during the night shift on a specific date a PSW pulled out the resident's call bell in their room because the resident used the call bell frequently. The resident was not able to access the resident-staff communication system during the night.

The Administrator acknowledged in an interview that a PSW deactivated the call bell and made it inaccessible for the resident during a specific shift.

The Administrator said that it was the home's expectation that the resident-staff communication and response system be on at all times, easily seen and accessed by the resident. [s. 17. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times and is on at all times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken related to alleged neglect and abuse of a resident, and every action taken in response to this incident.

A review of the Ministry of Health and Long-Term Care (MOHLTC) incident number 15285 submitted to the Ministry of Health (MOH) on a specific date showed that the Director of Care was made aware that a resident was seated in their assistive device chair, facing the wall in their room. The brakes were on the assistive device and the room was dark. It was not known how long the resident was left in the room. The resident was not in any duress. The home was conducting an investigation, the administrator was also notified.

A clinical record review for the resident showed a progress note completed on a certain date by the DOC indicated that the resident's family member found the resident seated in their assistive device, facing the wall in their room. The breaks were on the assistive device. The resident's family member voiced concerns to the DOC, who had then followed up with reporting to the MOHLTC. Critical Incident System (CIS) reference number 15285.

A review of the CIS reports submitted to the MOHLTC by the home showed no record of a critical incident submitted by the home related to this incident. The MOHLTC had received a message from the home through the LTC home emergency pager (report number 15285) informing the Ministry of the incident.

The Administrator and the DOC said in interviews that they did not have a documented record of a report that was submitted to the Director for the allegations of neglect of the resident. They said that they did not have any records of the investigation that took place with the staff at that time, and no record of any action taken related to that incident.

The Administrator and the DOC said that it was the home’s expectation that a report would be made to the Director for any allegation of abuse or neglect of the resident that would include specified information as per the Long-Term Care Home Act including the investigations and any action taken in regards to those allegations. [s. 23. (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 to report to the Director the results of every investigation undertaken related to alleged neglect and abuse of a resident, and every action taken in response to this incident, to be implemented voluntarily.

WN #6: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A review of Critical Incident System (CIS) report submitted on certain date showed that on specific date and time staff reported a missing controlled substance from a resident's pain medication pack. Requests to amend the CIS report were made on two different dates.

A review of the Medication Incident Form completed by a RN on specific date showed that during the controlled substance count it was noted that a controlled substance tablet was missing.

During a telephone interview the RN said that when they were informed of the missing controlled substance they called and informed the DOC, the DOC directed them to complete a Medication Incident Form and that when the DOC was in the home next they would submit a CIS report.

On a certain date the DOC said in an interview that they were called by the RN and were informed that a controlled substance was missing.
The DOC said that they did not give the RN any direction to submit a CIS report as they were planning to submit one the next day when they were in the home, they said that they were the person responsible for submitting and updating the CIS report. They said that they did not submit a CIS report as per requirements in the legislation and that they did not update the CIS report when information was requested as they were very busy and overwhelmed with work and other duties they had to complete in the home.
The DOC acknowledged that the CIS report was not submitted no later than one business day from the date of the incident and that the CIS report update was not completed when requested by the Director.

On a certain date the Administrator acknowledged in an interview that the CIS report was submitted seven business days after the incident occurred and that the CIS report was not updated as requested by the Director. [s. 107. (3) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director was informed of an incident of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), to be implemented voluntarily.

WN #7: 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 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.

During this inspection this non-compliance was found to be a supporting evidence for Compliance Order issued under inspection #2017_607523_0021 (log #014699-17, 018683-17, 019033-17).

A) Ontario Regulation 79/10 s. 30. (1) stated "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."

Ontario Regulation 79/10 s. 48 (1) stated "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

On a certain date a family member of a specific resident told the Inspector that they went to visit the resident on a specific date and they noticed that the resident was very tired and did not seem well. This family member said that at that time they became aware that the resident had been deteriorating for specific number of days with specific signs and symptoms and was concerned that the staff in the home did not identify the change in the resident's status earlier. They said they requested that the resident be sent to hospital. This family member said they did speak with the Director of Care (DOC) about these concerns.

The clinical record for the resident included the following documentation:
-A progress note on a certain date showed that the resident had a fall, no injury. Resident was assisted back to bed. Vital signs stable.
- A "Post Fall Assessment" completed on a certain date showed a specific change in the resident's status and that the physician was notified.
- A physician progress note on a certain date showed that the resident had a fall. Resident was doing well with no symptomatic complaints. Fall with no obvious injuries; complete fall protocol; notify MD if change in behaviour or unwell.
-The documented vital signs showed changes in a specific status at eight different occasions.
-Head Injury Record on a certain date documented resident as confused or sleeping at each time of assessment and a specific change with three documented missed assessments on certain times.

There was no documented evidence that this resident had been assessed or the plan of care was revised related to the specific vital sign by a RN or physician between the post fall assessment and the transfer to hospital.

On a certain date the Director of Care (DOC) said that the home had policies in place related to Falls Prevention which included the Falls Intervention Risk Management (FIRM) Implementation CPM-C-20 as well as Head Injury Routine NAM-F-65.

The home's policy titled "Falls Intervention Risk Management (FIRM) Implementation CPM-C-20" last revised January 2014, stated "After a fall the Physician/nurse practitioner will be notified when appropriate and as indicated by the Registered Staff's clinical assessment. The Resident will be monitored as per the Physician's/nurse practitioner order."

The home's policy, which was in place at the time of the resident's fall, titled "Head Injury Routine" last revised February 2016, stated "Notify the physician if there is a sudden change in vital signs and/or neurological assessment."

On a certain date a RPN reported that usually they assessed residents' vital signs weekly or monthly and when there had been a fall and the resident was on a HIR they needed to assess more often. The RPN said if something changed with a resident they were expected to notify the Registered Nurse who would then decide if the physician needed to be contacted. Inspector reviewed with the RPN the progress note they had documented on a specific date, RPN acknowledged that they had documented that the resident's specific vital sign was very low. RPN said the action they had taken was to notify the family who said they wanted the resident to be monitored. RPN said they thought they had reported that concern to the RN for assessment but they had not documented this action.

On a certain date a RN said they did not recall any of the details of the fall that the resident had including their involvement in the fall assessment. Inspector reviewed RN's post fall documentation with them. RN acknowledged that they had documented in this assessment that the resident's specific vital sign was considered to be low but said they thought maybe the resident's vital sign was always low. RN said they thought that they had called the doctor to notify them and though they were told just to monitor the heart rate and acknowledged that the details of this referral for assessment had not been documented.

On a certain date a RN said they were familiar with the resident but did not recall any details regarding a fall or change of condition. RN acknowledged that they had been working in the home as the RN on specific dates. The RN said they did not recall being notified of any concerns regarding the resident's specific low vital sign. RN said that their

usual practice was to document any assessment that they completed on residents in the progress notes and would follow-up with physician if needed. RN said that a specific low vital sign would be of concern and would need to be assessed.

On a certain date a Locum Physician reported that they had assessed the resident after the fall and at that time there were no concerns identified regarding the resident's well-being. The Locum Physician said they had not been notified by the staff in the home after that assessment regarding concerns with the resident's vital signs or overall health status until after they were sent to hospital. The Locum Physician said it was their expectation that they would be notified of a specific low vital sign or change in condition in order for the resident to be assessed and if needed treatments changed.

During an interview with the DOC, they said that it was the expectation that the staff in the home would comply with the home's falls prevention policies including that they would have completed the HIR documentation and that the RN and physician would be notified of vital signs that were not within the resident's normal range. (630)

B) Ontario Regulation 79/10 s. 114. (2) stated "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

A review of CIS report submitted on a certain date showed that on a specific date staff reported a missing controlled substance from a resident's pain medication pack.

A review of the Medication Incident Form completed by a RN on a specific date showed that during the controlled substance count it was noted that a controlled substance was missing.

A review of the internal investigation notes related to the missing controlled substance showed a Medication Incident Form completed by a RN on a specific date stating that " A RN documented on the controlled substance count sheet that at a specific time one tablet of a specific medication was given to the resident but there was no signature on the Electronic Medication Administration Records (EMAR)".

A review of the home's policy Medication/Treatment Administration Records, index:

G-90, effective date: January 2014, showed that "when a Registered Staff administers medication/treatment, this person must initial MAR/TAR sheet under correct date and time of administration or assign their electronic initials with electronic medication and treatment administration software".

The RN said in an interview that at the beginning of their specific shift they completed the controlled substance count but they did not notice that a controlled substance was missing. on a specific date and time the resident asked for their pain medication, the RN took the medication out of the controlled substance box, signed on the controlled substance count but did not sign on the EMAR for the resident. The RN said that the expectation was for the EMAR to be signed after the medication was consumed by the resident but they were very busy and by the time they came back to sign the EMAR another nurse had discovered the missing controlled substance and the missing signature and completed a Medication Incident report.

A review of the controlled substance sheet for the resident with the DOC showed that on a certain date and time a controlled substance was dispensed to the resident. A review of the EMAR for the resident with the DOC showed that there was no signature or initials for the dispensed narcotic for the specified date and time.

The DOC said in an interview that it was the home’s expectation for the staff to comply with the home’s policy and to sign the EMAR as soon after the medication was administered to the resident.

The Administrator acknowledged in an interview that the home's policy was not complied with. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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).

Findings/Faits saillants :

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

During this inspection this non-compliance was found to be a supporting evidence for Compliance Order issued under inspection #2017_607523_0021 (log #014699-17, 018683-17, 019033-17).

A) Section 2(1) of the Ontario Regulation 79/10 defined physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

The home submitted CIS report to the MOHLTC on a certain date which identified an "incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status." This report stated that a resident had been "striking out at staff and agitated" and that another resident had gone into the first resident's room and was later found on the floor by staff and the fallen resident stated that the resident had "pushed" them. The report stated that the fallen resident had an injury related to the fall.

On a certain date a RPN told Inspector that they were working at the time when the resident fell and was the one who completed the post fall assessment. The RPN said that the resident had told staff that the other resident had pushed them and that due to the fall the resident sustained an injury. The RPN said they had notified the RN at the time of the fall and did report that the resident had told staff that they had been pushed by another resident. The RPN said that this incident was unwitnessed and they were not sure if at the time it was considered resident to resident abuse. The RPN said that for any situation of potential resident to resident abuse they were to report it right away to the RN who would then respond and notify the Administrator.

The home's written policy, which was in effect at the time of the incident of between the residents, was titled "Resident Non-Abuse" with effective date February 2012. This policy included the following direction for staff:
- The policy stated that physical abuse included "pushing."
- "In any case of abuse or suspected abuse, the employee or any other person witnessing or having knowledge of an incident shall verbally report the incident immediately to their department head or immediate supervisor or during evening and night hours to the most senior supervisor available."

- "Regardless of the action taken, the individual to whom the incident has been reported will conduct an inquiry and complete a preliminary written report before going off duty."
- "The findings of the preliminary inquiry must be conveyed immediately to the Administrator to decide a) whether sufficient evidence exists to substantiate any allegation of abuse as defined b) whether further investigation is required to substantiate abuse."

The clinical record for the resident included a progress note completed on a certain date indicated that the resident was found on the floor in their spouse's room. This note also stated that the resident was telling PSWs and RPN that their spouse pushed them and they "fell landing hard on the floor." This progress note stated "RN notified" and resident was transferred to the hospital. A progress note completed on a certain date and time stated "Administrator notified regarding transfer to hospital."

On a certain date the Administrator told the Inspector that they had spoken with the DOC and reviewed the documentation regarding this CIS report. The Administrator said that staff reported the incident to them as they were on call in the evening at the time. The Administrator said that they thought that staff had reported that a co-resident had pushed the resident and the two residents were separated and the resident was sent to hospital right away. Administrator said they were looking at this CIS report from the perspective of a fall and the main focus was the injury. Administrator said this incident was in their risk management as a fall and was submitted to MOHLTC as a fall. Administrator said there was no documentation to show that this had been investigated as an alleged resident to resident physical abuse. During the interview Inspector and Administrator reviewed the home's written policy on the prevention of abuse that was in place at the time of the incident of between the residents, Administrator acknowledged that this policy had not been followed as this incident potentially met the definition of an alleged physical abuse. Administrator said that it was the expectation that staff and management were to comply with the policy in terms of immediate reporting of an incident of potential abuse to management and documenting an investigation into the alleged abuse.

B) Section 2(1) of Ontario Regulation 79/10 defined sexual abuse as "any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

The home submitted CIS report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date which was identified as potential sexual abuse. This report stated that on a specific date a resident who had "ongoing specific responsive behaviours since

admission." This report stated that a resident had reported to a RPN that they had witnessed the resident exhibiting the specific behaviours towards another resident's."

On a certain date a RPN said that the resident had a history of specific responsive behaviours. The RPN said that they had not personally witnessed these incidents but that it was the expectation in the home that these types of incidents would be reported to the RN right away.

On a certain date a PSW said that the resident had a history of specific inappropriate behaviours. The PSW said that most of the behaviours were directed towards staff and they had not personally witnessed any behaviours towards other residents. PSW said they were aware that there had been an incident with another resident. PSW said it was the expectation in the home that these types of incidents would be reported to the RN right away.

On a certain date a Behavioural Supports Ontario (BSO) PSW said on a certain date BSO received a referral for the resident related to specific responsive behaviours. BSO PSW said they provided education to staff regarding the behaviours as the resident had been having these types of behaviours directed towards staff and residents. BSO PSW reviewed a certain assessment charting for the resident and indicated that there had been documentation of "specific behaviour" towards another resident on a specific date but there were no other documented details. BSO PSW said there had been a reported incident of specific responsive behaviour towards another resident and after this incident the resident had been sent to hospital for assessment.

The home's written policy, which was in effect at the time of the incident, was titled "Resident Non-Abuse" with effective date February 2012. This policy included the following direction for staff:
- The policy stated that physical abuse included "inappropriate verbal exchange of a sexual nature or unsolicited sexual contact of any kind."
- "In any case of abuse or suspected abuse, the employee or any other person witnessing or having knowledge of an incident shall verbally report the incident immediately to their department head or immediate supervisor or during evening and night hours to the most senior supervisor available."
- "Regardless of the action taken, the individual to whom the incident has been reported will conduct an inquiry and complete a preliminary written report before going off duty."
- "The findings of the preliminary inquiry must be conveyed immediately to the Administrator to decide a) whether sufficient evidence exists to substantiate any

allegation of abuse as defined b) whether further investigation is required to substantiate abuse."

A clinical record review for the resident showed that the resident had expressed responsive behaviours towards other residents, no documentation that that the RN or any management in the home had been notified of the incident. The communication techniques were not working, a referral was completed to the BSO program and the resident was assessed by the BSO team. The resident was assessed by an external resource team but there was no documentation for the responsive behaviours. The resident's behaviours continued to occur.
A progress note completed on a certain date which indicated that a resident's family member stated that it was reported to them that a resident was groping their family member and stated "reported to administrator with follow up investigation."

On a certain date the DOC and the Administrator told Inspector that they had been involved in investigating this incident. The DOC said that there was a staff member who had been terminated as they had not reported the alleged abuse and had not completed appropriate documentation related to the incident between residents. Administrator said that they had found out about the alleged abuse when reviewing the progress notes. The DOC and the Administrator said that along with the former ADOC they had conducted interviews with various staff regarding the incident, but these were not all documented. Administrator said that no staff had reported this incident of alleged abuse to them or any of the management team members in the home. Administrator said that based on their interviews it was identified that the RN had not been informed of the incident at the time. Inspector reviewed the progress notes with DOC and Administrator regarding the resident's specific behaviours and they said that no staff had reported these incidents and there had been no investigation. Administrator said it was the expectation that staff would report any allegations of abuse and staff had received education on reporting abuse prior to the incident.

Administrator said that it was the expectation that staff and management were to comply with the policy in terms of immediate reporting of potential abuse to management and documenting an investigation into the alleged abuse. [s. 20. (1)]

Issued on this 5th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523), AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2017_607523_0033
Log No. / No de registre :	007403-17, 011823-17, 014514-17, 014821-17, 015976-17, 017624-17, 021790-17, 022211-17, 023214-17, 024872-17, 025974-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 4, 2018
Licensee / Titulaire de permis :	SHARON FARMS & ENTERPRISES LIMITED 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, 000-000
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Katie Villeneuve-Rector

To SHARON FARMS & ENTERPRISES LIMITED, 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. 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.
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.
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.
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).

Order / Ordre :

The licensee shall ensure that a written record is kept relating to each evaluation under paragraph 3 that includes the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that a written record was kept relating to each evaluation under paragraph 3 that included the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Ontario Regulation 79/10 s. 48 (1) states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain."

A review of the annual evaluation of the Skin and Wound Program, Falls Management Program, Pain Management Program and Continence Care and Bowel Management Program showed that there was no record of the names of the persons who participated in the evaluation, and no record of a summary of the changes made and the date that those changes were implemented.

On a certain date the Administrator and the Director of Care (DOC) said in an interview that the evaluation of the above specified programs were completed before they assumed their current roles in the home. They said that the annual evaluations had no record of the names of the persons who participated in the evaluation, and no record of a summary of the changes made and the date that those changes were implemented.

The Administrator and the DOC said that they planned to complete program reviews and annual evaluations of the required programs with the interdisciplinary teams in the near future.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to resident. The scope of the non-compliance was isolated, this area of non-compliance was not previously issued. [s. 30. (1) 4.] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;
(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
(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).

Order / Ordre :

The licensee shall ensure that 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; 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 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.

Grounds / Motifs :

1. The licensee has failed to ensure that the matters referred to in subsection (1) were implemented in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; at least annually, the matters referred to in subsection (1) were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and a written record was kept relating to each evaluation under clause (b) that included 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.

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

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date which identified an "incident of alleged staff to resident abuse/neglect." This report stated that a Registered Nurse (RN) was called to a resident's room by a Personal Support Worker (PSW), the RN found the resident's call bell was pulled out and something was plugged in instead. The call bell was placed on the bed side table.

On a certain date a PSW said: " the resident had lots of responsive behaviours, they yelled out and used the call bell a lot" The PSW said that the resident was referred to Behavioural Supports Ontario (BSO), they had completed a certain assessemnt for the resident but they were not informed about the results of the assessment or the interventions that were put in place.

A review of the home's policy titled "Responsive Behaviours Management", Index: BM-L-05, last revised September 2017, showed under procedure that upon occurrence of an episode of responsive behaviour a registered staff would initiate a post-behavioural huddle to review the behaviour in conjunction with the care team. The purpose of the huddle was to review the behaviour exhibited, strategize to minimize or eliminate the recurrence of the behaviour and to determine effectiveness of current strategies and to ensure that all required information had been collected and documented.

A clinical record review for the resident showed that a certain assessment was

completed on the resident, resident had not been seen since and was discharged by BSO.

In an interview a RPN said that they did not complete a post-behavioural huddle when a resident exhibited responsive behaviours.

In an interview a RPN said that a certain assessment was not always being done in the home and that the post-behavioural huddle was not being done in the home.

On a certain date a BSO-PSW said in an interview that part of the screening protocols to identify triggers and set up interventions was for staff to complete the assessment charting and the post-behavioural huddle.

A clinical record review for the resident with BSO-PSW showed the following: the assessment charting completed at a specific period of time was missing 107 out of 371 entries and there was no post-behavioural huddle completed for the resident. The BSO-PSW said that staff almost never completed the assessment charting and sometimes it was not accurate. They said that the post-behavioural huddle was also not being completed when residents exhibited responsive behaviours.
The BSO-PSW said that they had no information as to why the resident was referred to BSO or what assessments were completed after the assessment charting was done. They said that they had been part of the BSO team for two years but they did not take part in any evaluation completed for the responsive behaviours program.

In an interview the Administrator and the DOC acknowledged the screening tools identified in the Responsive Behaviours Management policy and procedures were not fully or accurately being completed by the staff. They said that they were not sure if the annual evaluation of the responsive behaviour program was completed, they were not able to find a written record relating to the evaluation that included 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.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to resident. The scope of the non-compliance was widespread, this area of non-compliance was not

previously issued. [s. 53. (3)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

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. 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 shall ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, 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 identifying and implementing interventions.

Grounds / Motifs :

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

A) The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date which identified an "incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status." This report stated that a resident had been "exhibiting behaviours at staff and was agitated" and that this resident had pushed another resident who had a fall that resulted in an injury. The report also stated that the resident "has

a history of behaviours and staff were managing behaviours effectively and resident was not displaying agitated behaviours.

On a certain date a BSO PSW told Inspector that the resident had a history of responsive behaviours directed towards staff and other resident that was pushed down. The BSO PSW said the other resident tended to hover around the resident and then the resident would have a quick reaction and strike out at them. The BSO PSW said that they were aware that the other resident had a fall and that staff thought that the resident had pushed them. BSO PSW said that the BSO RPN has been responsible for the assessments and interventions for the residents in that area and therefore they were not sure what may have been done regarding resident's responsive behaviours. BSO PSW said that the BSO RPN was not available to interview at the time of the inspection as they were on a leave from the home. BSO PSW said that the Resident Care Coordinator was the new temporary lead for the BSO program and had not been involved in the assessments or interventions within the program at the time of the incident between the residents.

On a certain date a BSO PSW told the Inspector that they had reviewed the clinical chart for the resident and found that these showed that the resident did have behaviours related to aggression towards another resident. BSO PSW said there had been a referral to the BSO team on a certain date related to physical aggression towards the other resident which resulted in a fall. This referral had been documented on the referral form as being followed-up by the BSO RPN. BSO PSW said that based on the documentation there was a BSO progress note that the BSO RPN had spent time with the resident and suggested pain monitoring but there was no documented assessment. BSO PSW said that usually they would assess a resident using specific assessments. BSO PSW said that there was no documented evidence that interventions were implemented for the resident at that time related to aggressive behaviours towards another resident. BSO PSW said there was another referral made to BSO on a certain date, which showed that the resident had struck another resident. They said that this referral form did not include a date or documentation to show that the BSO lead had addressed the referral and stated that assessment was initiated. BSO PSW said that the assessment's charting was initiated but was incomplete as staff had not documented the observed behaviours as required on the form. BSO PSW said there was no other observed assessment form or documentation of assessment regarding this referral in the progress notes or the BSO documentation. BSO PSW said that

they had been off work at the time of the referral and was not involved in the assessment or development of interventions for the resident at that time.

On a certain date a PSW said they worked in the home on a casual basis and did provide care to the resident and the other resident. The PSW said that the resident was having some responsive behaviours towards staff but was not aware of any concerns with responsive behaviours that were directed towards other residents. PSW said that they knew the other resident tended to check on the resident regularly but did not think that the other resident had the tendency to go into the resident's room. The PSW said they would look in the plan of care to find out about responsive behaviours including the interventions that were in place.

On a certain date a RPN said that they were aware that the other resident had a fall and that it was reported by them that the resident had pushed them. The RPN said that prior to the fall the other resident was independent with mobility and did not have a history of falls, but due to the fall they were sent to hospital for treatment. The RPN said that prior to this incident the resident had been known to be aggressive with the other resident as well as with staff. RPN said that the resident had a history of specific responsive behaviours or aggressive behaviours towards anyone. RPN said that they made adjustments in the resident's specific medications and added an as needed dose of a specific medication but otherwise the resident had no further changes in medications or changes in interventions related to these behaviours. When asked about the specific incident RPN said that the resident was aggressive towards the other resident but there was no injury at that time.

On a certain date a RPN said that they had been working at the time when the other resident had the fall and they had completed the post fall assessment. The RPN said the fall was not witnessed by staff and that the other resident was found on the floor and the resident was also in the same room at the time. RPN said that the other resident told the staff that the resident had pushed them. RPN said that prior to the fall the resident had some responsive behaviours towards the other resident as they would raise their voice or their fist at them and the staff would need to redirect the other resident away from the resident. RPN said that residents' observed or reported responsive behaviours were to be documented in PCC as a progress note. When asked how they would know if there were assessments and interventions in place for a resident related to responsive behaviours, RPN said they would look in the plan of care as well as

the BSO binder at the desk. When asked about the assessment charting, RPN said that these were completed by the PSWs and RPNs during the shift and that the assessment charting was not always being completed within the home. Inspector reviewed the BSO referrals with RPN. They said that they had made referrals to BSO on two specific dates regarding the resident's responsive behaviours towards the other resident. RPN said they recalled that assessment charting had been initiated on one occasion, but otherwise could not recall assessments or interventions that had been implemented related to these referrals apart from redirecting the other resident away from the resident.

The clinical record review for the resident showed that the resident was agitated and other residents were complaining that resident was loud and physically aggressive sometimes towards staff and other residents. A BSO referral was completed on a certain date, there no documentation of an assessment or documentation regarding responsive behaviours towards the spouse.
- A physician progress note completed on a certain date which stated "agitation and aggression triggered usually by care. Recently discharged from BSO as no current issues.
- A progress note completed on a certain date which stated "resident was on a certain assessment charting, tracking aggressive behaviours" and "BSO writer reviewed the charting today with findings that it was three quarters complete. From what was completed resident did not present any signs of aggression throughout the day or evening shifts."

The plan of care for the resident included a focus "altered behaviours related to behavioural and psychological symptoms due to a certain diagnosis as evidence by episodes of verbal and physical aggression, refusing care and being disruptive." The documentation showed this section of the plan of care was last revised earlier in the year and did not include the identification or interventions related to the responsive behaviours towards the other resident. The BSO written plan of care was dated as last revised recently and did not include the identification or interventions related to the responsive behaviours towards the other resident.

On a certain date the Administrator said they had been informed by staff of CIS report in which the resident was reported to have pushed another resident resulting in an injury. The Administrator said that it was the expectation in the home that when there was resident to resident altercations then there would be assessments completed and interventions implemented. Administrator said that

they reviewed the documentation regarding the incidents that had occurred between the two residents and acknowledged that the resident's responsive behaviours had not been assessed and the plan of care had not been updated to identify the risk of physically responsive behaviours towards their spouse or include interventions to minimize the risk of these behaviours.

Based on these interviews and record review the home had failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents. Staff and management in the home were aware of the potential risks, through information provided by other residents and staff observations, but interventions were not identified through the documented plan of care or consistently implemented.

B) The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date, which was identified as a potential resident to resident abuse. This report stated that on a certain date, a resident had "ongoing responsive behaviours since admission."

The home immediately notified the MOHLTC on a certain date of an alleged resident to resident abuse. The CIS report showed that staff witnessed the resident grabbed another resident.

On a certain date a RPN said that the resident had a history of specific responsive behaviours. The RPN said they were aware of an incident when the resident had touched another resident. When asked what interventions were in place for the resident's specific responsive behaviours, RPN said that the resident received medications for behaviours, staff were watching the resident closely and BSO was involved. RPN said the resident had difficulty in communication.

On a certain date a PSW said that the resident had a history of a "specific behaviours" and they thought these behaviours had mainly been directed towards staff. When asked if there were any interventions for the resident's behaviours they said that BSO would tell them suggestions on how to speak to this resident. When asked if there were any interventions for the resident regarding potential specific behaviours towards other residents, PSW said they could not think of other interventions and that sometimes the resident did not understand what staff were saying to them due to a difficulty in communication and specific medical condition.

A clinical record review for the resident showed that the resident had expressed responsive behaviours towards other residents, no documentation that that the RN or any management in the home had been notified of the incident. The communication techniques were not working, a referral was completed to the BSO program and the resident was assessed by the BSO team. The resident was assessed by an external resource team but there was no documentation for the responsive behaviours. The resident's behaviours continued to occur. The clinical record included no documented assessments of the resident's specific responsive behaviours completed by registered staff in the home, the BSO team or external resources in 2016 or 2017.

The plan of care for the resident included a focus "altered behaviours related to cognitive decline." The focus did not identify that the resident had specific responsive behaviours directed towards other residents or include triggers for these behaviours. The plan of care did not include the identification or interventions related to the specific responsive behaviours towards other residents. The documentation showed this section of the plan of care was not revised between specific periods of time.

On a certain date the intervention section in the plan of care was updated to direct staff to "intervene as needed to protect the rights and safety of others. Approach/speak in calm manner. Divert attention. Remove from situation and take to another location as needed." No other interventions related to these responsive behaviors were added to the resident's plan of care between specific periods of time. There was no BSO written plan of care for the resident.

On a certain date a Behavioural Supports Ontario (BSO) PSW said that on a specific date BSO received a referral for the resident related to specific responsive behaviours. BSO PSW said they provided education to staff on a specific date regarding specific behaviours as the resident had been having these types of behaviours directed towards staff and residents. BSO PSW reviewed a specific assessment charting for the resident and indicated that there had been documentation of "specific behaviour" towards another resident on specific date and time but there were no other documented details and this assessment charting was incomplete. BSO PSW said that the BSO RPN had tried to make a referral to the Behavioural Response Team but was told that they did not accept referrals for a resident to see the psychiatrist or to review medications and BSO PSW was not sure what happened with the referral. BSO

PSW reviewed the BSO documentation and assessments for the resident with Inspector and acknowledged that there were no assessments completed apart from the progress note BSO PSW had completed on a certain date. BSO PSW said that they were not responsible for updating the plan of care as that was the responsibility of the BSO RPN. BSO PSW acknowledged looking at the plan of care that there was no documented triggers or interventions related to the specific responsive behaviours towards other residents. BSO PSW said they had implemented specific interventions that staff were to use as an activity for the resident and acknowledged that this intervention was not referenced in the plan of care. BSO PSW said that there were changes to the resident's medications made when in hospital but otherwise no involvement in assessments by external resources.

On a certain date the DOC and the Administrator told the Inspector that they had been involved in investigating these critical incidents related to alleged abuse. When asked what interventions were in place for the resident's responsive behaviours prior to the incident, the Administrator said that they had tried to put interventions to keep the resident busy. The DOC said that there had been referrals to external resources but no one had been in to assess the resident prior to or after the specific incident.

During a follow-up interview on a certain date the Administrator told Inspector that they had reviewed the documentation for the resident. The Administrator said that based on their review of BSO documentation and plan of care, there had not been triggers identified related to the resident's specific responsive behaviours or interventions in place to minimize risk of altercations with other residents. The Administrator said the plan of care and interventions were focused on behaviours towards staff versus other residents. The Administrator said that it was the expectation in the home that when there was risk of resident to resident altercations then there would need to be assessments completed and interventions implemented.

Based on these interviews and record review the home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents. Staff and management in the home were aware of the potential risks, through information provided by other residents and staff observations, but interventions were not identified through the documented plan of care or consistently implemented.

During the inspection this non-compliance was found to have the severity level of actual harm/risk. The scope of the non-compliance was a pattern, this area of non-compliance was not previously issued. [s. 54.] (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 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

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

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 4th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Ali Nasser

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