Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2016_395613_0019	001035-16	Resident Quality Inspection

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

LISA MOORE (613), JENNIFER LAURICELLA (542), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 31 - November 4, 7 - 10 and 14 - 18, 2016

The following intakes were completed during this inspection:
Follow Up log related to a previous compliance order #001 (CO) related to nutrition care and hydration programs
Follow Up log related to a previous compliance order #001 (CO) related to reporting certain matters to the Director.
Two critical incident reports submitted by the home related to resident to resident abuse;
Two critical incident reports submitted by the home related to staff to resident abuse;
Two complaints submitted to the Director related to concerns with the provisions of care and alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), Resident Quality Manager (RQM), Medical Director (MD), Physician Assistant (PA), Resident Assessment Instrument (RAI) Coordinator, Dietary Services Manager (DSM), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNS), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed various licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **16 WN(s)**
- **9 VPC(s)**
- **6 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 68. (2)	CO #001	2016_463616_0012	542

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

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

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

(A) During the inspection, resident #005 was identified through the census review as having altered skin integrity and a worsening area of altered skin integrity.

Inspector #543 reviewed resident #005's health care record. A review of this resident's care plan indicated that, resident #005 had an area of altered skin integrity. An intervention identified to administer altered skin integrity care as per physician orders.

A review of this resident's admission progress note, dated in May 2016, identified that resident #005 was admitted to the home with an area of altered skin integrity. A progress note, dated in May 2016, indicated that the registered nurse had completed an assessment of the resident's areas of altered skin integrity.

Inspector #543 reviewed resident #005's skin and wound assessments in their health care record. A head to toe assessment completed in May 2016, identified the resident had areas of altered skin integrity. In June 2016, an assessment completed indicated an area of altered skin integrity. In September 2016, an assessment completed indicated

two areas of altered skin integrity.

In November 2016, Inspector #543 interviewed RN#107, who stated that resident #005 never had an area of altered skin integrity. The Inspector reviewed the resident's care plan with the RN, and confirmed that the care plan identified an area of altered skin integrity, this RN stated again that the resident never had an area of altered skin integrity and verified that care plan was inaccurate.

In November 2016, Inspector #543 interviewed RN #110, who stated that resident #005 had an area of altered skin integrity. This RN verified that the resident had had this area of altered skin integrity since their admission to the home.

In November 2016, the Inspector spoke with an interdisciplinary team member, who confirmed that resident #005's care plan was not up to date.

(B) During the inspection, resident #002 was identified as having a fall in the last 30 days.

The Inspector reviewed the resident's most current care plan accessible to staff that identified under the Falls/Balance Problem, an intervention that the resident was to have a device on their bed.

On November 7 and 8, 2016, Inspector #613 observed resident #002 lying in bed with no device on the resident's bed.

The Inspector interviewed PSW #102, PSW #103 and an interdisciplinary team member, who all stated that a device had been trialed in the past, but had been removed, as the resident kept damaging the device in attempts to deactivate.

On November 8, 2016, the Inspector interviewed RN #107, who stated they thought the device was discontinued and checked the electronic care plan on MED e-care, it did not identify the resident was to have a device. Inspector #613 showed the RN the paper care plan that was accessible to staff, which identified that resident was to have a device in place. The RN confirmed that the electronic and paper care plans were not updated with the same information.

The Inspector reviewed the e-notes on MED e-care in October 2016 and November 2016, which failed to identify when and why the device had been removed off of the bed.

RN #107 reviewed the e-notes on MED e-care and confirmed there was no documentation to identify if the device had been discontinued. RN #107 stated they were not sure what had occurred. The RN put another device on the resident's bed and updated the paper and electronic care plans.

The Inspector interviewed the an interdisciplinary team member and RPN #101 on the same date. The interdisciplinary team member showed the Inspector on MED e-care e-plans, the documentation which identified that device had been removed and deleted from the electronic care plan by RN #110 in October 2016; however, RN #110 had not updated the paper care plan that was accessible to direct care staff. Both the interdisciplinary team member and RPN #101 confirmed that the electronic and paper care plans were not updated with the same information.

On November 17, 2017, Inspector #613 interviewed the ED/DOC, who verified that it was their expectation that registered staff updated a resident's electronic care plan when their interventions or status changed. The ED/DOC stated then a paper copy must be printed and placed on the unit as PSW's do not have access to the electronic care plan. [s. 6. (2)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of residents #005, #010 and #014, so that their assessments were integrated and were consistent with and complemented each other.

(A) During the inspection, resident #005 was identified as having a worsening area of altered skin integrity.

Inspector #543 reviewed the resident's care plan which indicated that resident #005 had an area of altered skin integrity. An intervention identified that registered staff were to administer altered skin integrity care as per the physician orders.

A review of resident #005's health care record identified documented physician orders related to the resident's area of altered skin integrity. The physician's orders, dated May 2016 (resident's admission date), indicated, a specific treatment with specific dates to complete. There was no other order in the physician's order sheets to address the altered skin integrity care after May 2016.

On November 4, 2016, Inspector #543 interviewed RN #110, who verified there was an

order from resident #005's admission, May 2016, related to altered skin integrity care, and there was no other order in the physician's orders to address the altered skin integrity. They also confirmed that the admission order differed from what care was being done for the altered skin integrity at the time of the inspection.

A review of the resident's electronic progress notes (e-notes) dated, June 2016, indicated that the wound care lead, who was the Executive Director/Director of Care (ED/DOC), had assessed the resident's area of altered skin integrity and changed the treatment orders. The documentation, written by the ED/DOC, identified that there were new orders for the altered skin integrity, to provide a specific treatment.

During an interview with the ED/DOC, they verified that they had changed the physician's admission orders for resident #005's altered skin integrity care in June 2016.

On November 9, 2016, Inspector #543 interviewed the Physician Assistant (PA), who verified that it was the expectation that any change in a resident's altered skin integrity status would be reported to the Medical Director (MD) or Physician Assistant (PA) for further assessment. The PA stated that staff were expected to report to the MD or PA, the need for changes to orders and that staff were not to change the order.

(B) During the inspection, resident #010 was identified to have an urinary intervention.

Inspector #542 completed a health care record review for resident #010. The current care plan indicated that the resident's urinary intervention was to be completed monthly as ordered by the Medical Director. A physician's order, dated May 2016, indicated that the urinary intervention was to be completed at the urology clinic. The Treatment Administration Record (TAR) from June – July 2016 indicated that the urinary intervention was to be completed at the urology clinic. The TAR from August 2016, indicated that the urinary intervention was completed at the home on two dates in August 2016; however, a physician's order was not identified to support the completion of the intervention in the home.

On November 7, 2016, Inspector #542 interviewed RN #107, who indicated that they had completed resident #010's urinary intervention and the resident no longer required it to be completed at the urology clinic. RN #107 stated there was no order from the Medical Director (MD) to complete the urinary intervention at the home and that they had not consulted or collaborated the MD regarding this completion.

(C) During the inspection, resident #010 was identified as having, an area of altered skin integrity.

Inspector #542 reviewed the current care plan for resident #010. It was documented that the resident had areas of altered skin integrity to a specific area. The care plan indicated that resident #010 also had other areas of altered skin integrity.

The Inspector completed a health care record review and reviewed a form titled, "Stage II: Care Plan, Assessment and Treatment Sheet", from February 2016, which identified a specific treatment to be completed on specific dates, that the staff were to complete, this was decided in collaboration with the ED/DOC. There was no physician's order to identify the specific treatment plan. In February 2016, the Physician Assistant wrote an order for a consultation with a wound care specialist for the resident's specific areas of altered skin integrity. The e-notes from March 2016, indicated that resident #010 was assessed by the wound care specialist; however, there was no further documentation regarding the consultation. In May 2016, it was documented on the physician's order sheet that the ED/DOC had written an order for the resident's specific area of altered skin integrity, indicating a specific treatment. It was documented in the e-notes on MED e-care, that the RN on shift had called the ED/DOC to inform them, that the specific area of altered skin integrity was deteriorating. The ED/DOC had then provided the RN with new orders to start a specific treatment to the areas.

The health record for resident #010 identified a physician's order dated June 2016, that outlined new orders from the wound care specialist and a follow up appointment for July 2016. Inspector #542 was unable to locate any information as to whether resident #010 was seen by the wound care specialist or not in July 2016. The Resident Quality Manager (RQM) reviewed their appointment books and was unable to locate any documentation to support that resident #010 had gone to the follow up appointment. Also, a review of the e-notes in MED e-care did not identify that the resident went to the appointment.

On November 14, 2016, Inspector #542 interviewed the RQM and requested they contact the wound care specialist in an attempt to locate the missing orders or consultation notes.

On November 15, 2016, Inspector #542 was provided with consultation notes from the wound care specialist by the RQM. A consultation note dated March 2016, indicated that the wound care specialist had seen resident #010 and recommended that a specific

treatment be completed. A consultation note dated June 2016 indicated that they ordered a specific treatment. Also, a consultation note from June 2016 was provided to the Inspector. It was documented that a specific treatment should be instituted for resident #010's area of altered skin integrity. The Inspector spoke with the RQM who verified that they had not initiated the specific treatment for resident #010's specific area of altered skin integrity care.

On November 16, 2016, Inspectors #542 and #543 interviewed the Physician Assistant (PA), who indicated they were not aware that the wound care specialist had recommended the specific treatment for resident #010's altered skin integrity care in June 2016. Also, they were not aware of other recommendations from another consultation in June with the wound care specialist. The PA stated that the home had changed the orders and written their own direction regarding altered skin integrity treatments on several different occasions without notifying the PA or the Medical Director.

On November 17, 2016, Inspector #542 and #543 interviewed the Medical Director (MD) for the home. The MD indicated that they had not signed the Medical Directives for Wound Care Protocols. They stated that it was an expectation that the MD or PA be notified when a resident's altered skin integrity had deteriorated. The MD said that they were not aware that some of registered staff were using specific treatments without a physician's order.

(D) Inspector #543 reviewed a complaint that was received by the Director related to concerns with the provision of care provided to resident #014's altered skin integrity care. According to the complaint report, the resident's family felt that had the resident received proper altered skin integrity treatment, resident #014's altered skin integrity would not have worsened.

Inspector #543 reviewed resident #014's health care record which identified that the resident had areas of worsening altered skin integrity.

The Inspector reviewed the resident physician orders and identified the following:

April 2016: Wound Care Protocol for a specific area of altered skin integrity, physician was not notified.

April 2016: Wound Care Protocol for a specific area of altered skin integrity, infected,

physician not notified.

April 2016: Specific area of altered skin integrity, Prescriber Order Form in health care record filled out by the ED/DOC, and not signed by the MD or PA. The ED/DOC had informed the Inspector this form was a Medical Directive.

April 2016: Specific area of altered skin integrity, infected, Prescriber Order Form in health care record filled out by the ED/DOC, and not signed by the MD or PA. The ED/DOC had informed the Inspector this form was a Medical Directive.

April 2016: Specific order for a specific area of altered skin integrity, the order was placed on hold by the ED/DOC.

May 2016: Altered skin integrity orders stated to see previous orders, PA wrote a note stating, "that at what point do you want to allow this thing confer resistancy because other measures are being ignored". Specific interventions provided.

May 2016: Order to remind staff to follow order of specific intervention to promote healing of altered skin integrity.

July (no date specified): Wound care specialist commented that they would appreciate that their orders be followed, and that if they needed to be changed, they must be contacted, otherwise seeing them would be a waste of time for both the physician and resident. To continue with previous order.

September 2016: Order to increase nutritional supplement.

On November 8, 2016, Inspectors #542 and #543 interviewed the ED/DOC and RQM to determine who had the authority to change the physician orders related to altered skin integrity care. They both verified that no one other than the physicians and the PA could change orders. Inspectors #542 and #543 brought it to their attention that the orders had been altered by the ED/DOC. The ED/DOC stated they were not sure how that had occurred.

On November 15, 2016, Inspectors #543 and #542 interviewed the PA, who stated that there was a "massive communication failure" between management, the physician and the PA. The PA verified that it had occurred in the past whereby, MD or PA orders had been put on hold or changed by the registered staff. The PA stated it was not an

accepted procedure for registered staff to change MD orders, and this should not have occurred. They further indicated that there was an inconsistency with the altered skin integrity assessments, there was a lack of communication between staff to MD or PA when change in altered skin integrity status occurred and that it was very difficult for the MD and PA to locate documentation related to altered skin integrity concerns. The PA also verified that Wound Care Protocols and/or Medical Directives, had not been signed by the MD.

On November 17, 2016, Inspectors #542 and #543 interviewed the Medical Director (MD). The Inspectors showed the MD the two orders written from April 2016. The MD stated that they had not signed those Medical Directives for the Wound Care Protocols. The MD further stated that there were a number of issues with individuals changing orders or writing orders for altered skin integrity. They indicated that if an area of altered skin integrity had deteriorated, that the physician or PA should have been notified and that this was not always done. The physician stated that they were not aware that staff were using the protocols and instituting specific intervention to areas of altered skin integrity and verified this should not have occurred.

(E) Inspector #542 completed a health care record review for resident #010. A review of their care plan identified, the resident was to receive a specific amount of a nutritional supplement. A review of resident #010's current Medication Administration Record (MAR) did not indicate that the nutritional supplement was being provided to them.

A review of the health care record identified resident #010 was admitted to the hospital in May 2016 and returned to the home in May 2016 with new orders from the hospital. On the MAR from the hospital, there was no record regarding the nutritional supplement.

Inspector #542 interviewed the ED/DOC and the RQM, who both agreed that the registered staff should have reviewed resident #010's MAR that was in place prior to the resident's hospital admission and compared them to the hospital discharge orders to ensure no medications were missed. They then should have reviewed the medications with the Medical Director.

An assessment by the Registered Dietitian (RD) #108 in May 2016 for resident #010 indicated that the current nutritional plan was to be continued including the nutritional supplement due to the resident's areas of altered skin integrity; however, this was not identified on the MAR. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the plan of care was provided to the residents as specified in the plan, specifically for resident #008, resident #010 and resident #014.

(A) During the inspection, resident #010 was identified as having areas of altered skin integrity.

Inspector #542 completed a health care record review for resident #010. A physician's order, dated September 2016, indicated that resident #010 was to be up in their wheelchair no longer than a specific amount of time. The most current care plan available to the direct care staff indicated that the resident must be placed back to bed at certain times of the day. It was also documented that staff were to use a specific device for positioning in bed.

On November 8, 2016, Inspector #542 observed resident #010 to be up in their wheelchair at 1840 hours. Inspector #542 interviewed RN #107, who indicated that the staff had transferred the resident out of bed into their chair, at a specific time and the resident had been up longer than the specified amount of time indicated in their care plan and physician's order.

On November 9, 2016 at 1850 hours, Inspector #542 observed resident up in their wheelchair. The Inspector interviewed PSW #106, who verified that resident #010 was put in their wheelchair during the day shift. The resident had been in their wheelchair for a longer amount of time then specified in their care plan and ordered by the physician.

On November 14, 2016 at 1030 hours, resident #010 was observed up in their wheelchair. Inspector #542 interviewed PSW #114, who stated that resident #010 did not typically go back to bed at certain times of the day and sometimes they stayed up in their wheelchair for extended periods of time. PSW #114 indicated that when resident #010 was repositioned in bed, they would use a device underneath the resident to slide them up in bed. This was not the same device that was indicated in the resident's care plan.

(B) Inspector #543 reviewed a complaint that was received by the Director related to concerns with the provision of care provided to resident #014's altered skin integrity care. According to the complaint report, the resident's family felt that had the resident received proper altered skin integrity treatment, resident #014's areas of altered skin integrity would not have worsened.

Inspector #543 reviewed resident #014's care plan related to skin integrity which identified that the resident had areas of altered skin integrity. The interventions included, but were not limited to, altered skin integrity care as per physician orders, to ensure a specific intervention to promote healing to areas of altered skin integrity and nutritional supplement.

Through a health care record review, the Inspector identified that physician altered skin integrity orders had been altered, the altered skin integrity order had been placed on hold by the ED/DOC and the ED/DOC had completed a Prescribed Order Form that had not been signed by the Medical Director. Registered staff were implementing Wound Care Protocols and not notifying the MD. The resident at times did not have the specific intervention completed and there were missed doses of the nutritional supplement.

On November 15, 2016, Inspectors #543 and #542 interviewed the PA, who stated that it had occurred in the past whereby, the MD or PA orders had been put on hold or changed by the registered staff. The PA stated it was not an accepted procedure for registered staff to change MD orders, and should not be occurring. They further indicated that there was an inconsistency with the altered skin integrity assessments.

On November 17, 2016, the Inspector interviewed the RQM, who confirmed that registered staff had not followed the plan of care for administering the nutritional supplement. The RQM stated if the MAR indicated "not given" and there was no progress note attached for a reason of not given, then the nutritional supplement had not been given by the registered staff.

(C) During the inspection, resident #008 was identified for requiring further inspection regarding not having a plan to address their BMI (Body Mass Index) status.

Inspector #543 reviewed the resident's care plan which identified that resident #008 was at a nutritional risk. The care plan indicated that the resident was to receive a specific diet with specific texture and fluids and was to be seated at a specific table.

The Inspector reviewed the Dietary Master List that identified that resident #008 required a different specific diet and was to be seated at a different specific table. Staff referred to the Dietary Master List to provide the resident with, but not limited to the appropriate diet type and texture, serving instructions and seating location in the dining room.

On November 9, 10, 15 and 16, 2016, Inspector #543 observed the resident seated at a

specific table in the dining room, different from the table specified in their care plan.

On November 16, 2016, the Inspector interviewed the Dietary Services Manager #116, who verified that the Dietary Master List indicated the resident was to receive a different specific diet and was to be seated at a different specific table. They confirmed that the resident's care plan identified that the resident was ordered a specific diet and was to be seated at a specific table.

On November 17, 2016, the Dietary Services Manager #116 verified that the resident was supposed to receive a specific diet as per the resident's care plan and that the Dietary Master List contained the incorrect information related to resident #008's specific diet type as per the needs and preferences of the resident. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for resident's #005 and #002 is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and has failed to ensure that residents were not neglected by the licensee or staff.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed that resident #016 abused resident #017 in October 2016, by touching them inappropriately.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During an interview on November 17, 2016, the ED/DOC verified that all staff and management were aware of resident #016's previous history of inappropriate abusive behaviours of touching other residents, prior to the October 2016 incident involving resident #017.

A review of resident #016's health care record revealed that the resident had been involved in another alleged abuse incident with resident #017, prior to the October 2016 incident, on an earlier date in October 2016, where resident #016 inappropriately touched resident #017.

A further review of resident #016's health care record revealed that the resident had been involved in other alleged abuse incidents involving another resident, resident #018. The e-notes on MED e-care identified that in October 2016, resident #016 was witnessed touching another resident #018 inappropriately three times, as well as telling resident #018 to meet them in their room and later on the same date, wheeled resident #018 in their wheelchair into a vacant room. The e-notes identified that resident #018 was upset about the incident. On another date in October 2016, resident #016 was witnessed by RPN #104 being inappropriate again with resident #018 in an area of the home.

A review of resident #018's e-notes identified that the resident was upset after an incident in October 2016 when they had been touched inappropriately three times by resident #016 and brought into a unoccupied room. On another date in October 2016, resident #016 was again witnessed being inappropriate with resident #018 in an area of the home. There was no documentation in the e-notes on MED e-care to identify whether each incident was consensual or non-consensual, if an immediate investigation had occurred for each incident, if staff immediately reported to the Executive Director/Administrator or designate in charge of the home, if resident's SDM was notified of the incidents or the outcomes of the investigation, or that police had been contacted. The Inspector noted, each incident of witnessed abuse had not been reported to the

Director.

During the review of resident #017's health care record, the Inspector noted there was no documentation in the e-notes regarding the October 2016 incident, to identify that the incident was consensual or non-consensual, if an immediate investigation had occurred, the resident's response to the incident or to identify that resident #017's Substitute Decision-Maker (SDM) was notified of the incident or the outcomes of the investigation, or that police had been contacted for the two October 2016 incidents of abuse. The Inspector noted that the first October 2016 incident of witnessed abuse had not been reported to the Director, only the second October 2016 incident had been reported.

Other inappropriate incidents involving resident #016 documented in the e-notes on MED e-care were as follows;

-October 2016. Found touching an unidentified resident inappropriately

-October 2016. Found with another resident in their room, touching one another

The Inspector noted that resident #016's care plan had not been revised or updated until a specific date in October 2016, after resident #016 had acted in a inappropriate manner on several occasions toward residents #017 and #018. The home's physician was not updated about resident #016's behaviours until a specific date in October 2016, after resident #016 had acted in a inappropriate manner toward residents #017 and #018. The ED/DOC was unable to verify to the Inspector if each incident where resident #016 acted in a specific nature toward residents #017 and #018 had been consensual or not as they stated all residents had cognitive impairments. The ED/DOC also stated that no assessment was done to determine if any of the incidents where resident #016 acted in a specific nature toward residents #017 and #018 were consensual.

There was no close monitoring of resident #016 on the unit, to ensure they were not in close proximity or left unattended with other residents during specific time frames, until a later date in October 2016, when 15 minute checks were implemented, even though all staff were aware of resident #016's previous behaviours. The CI report identified that a referral to a specific agency would be made; however, this was not done.

On November 15 and 17, 2016, Inspector #613 interviewed the Executive Director/Director of Care, who stated that all staff, management, registered staff (RNs and RPNs) and personal support workers (PSWs) were aware of resident #016's

previous history of inappropriate behaviours. The ED/DOC was unable to provide investigation reports for each incident to the Inspector. They stated that they did not have any incident reports or investigation notes for each incident, rather they had talked to staff in regards to each incident. The ED/DOC stated they had not reported the incidents in October 2016, involving residents #017 and #018 to the Director as they had used the Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse as a guide to determine their decision not to report and could not determine resident #016's intent to abuse the residents due to their cognitive impairment.

A review of The Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse, identified that once the licensee becomes aware of alleged, suspected witnessed abuse of a resident and there are reasonable grounds to suspect that abuse has occurred or may occur the licensee is to immediately report suspicion and information to the Director (via CIS memo; required to report after hours pager outside business hours).

During interviews with the ED/DOC, they verified that the SDM's for residents #017 and #018 were not notified of each witnessed abuse incidents at the time of the occurrence. The ED/DOC confirmed that resident #017's SDM was notified of the first October 2016 incident on a later date in October 2016, thirteen days later when the second abuse incident occurred. The ED/DOC stated they were unaware that resident #018 had been upset following the October 2016 incident as RPN #119, who had documented in the e-notes on MED e-care had not reported that to them that resident #018 had been upset. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, included screening protocols, assessment, reassessment and identification of behavioural triggers that may have resulted in responsive behaviours, 2. Written strategies, included techniques and interventions, to prevent, minimize or respond to the responsive behaviours, 4. Protocols for the referral of residents to specialized resources where required.

Inspector #542 requested the ED/DOC, who was also the lead for responsive behaviours, to provide the Inspector with the home's responsive behaviour polices and procedures. Inspector #542 was provided with the home's policy titled "Responsive Behaviours Management". The Inspector reviewed the policy which failed to include

written approaches to care, screening protocols, assessments, reassessments and identification of behavioural triggers that may have resulted in responsive behaviours, written strategies that techniques and interventions, to prevent, minimize or respond to the responsive behaviours and protocols for the referral of residents to specialized resources where required.

On November 17, 2016, Inspector #542 interviewed the ED/DOC. The Inspector asked if all of the above information was developed to meet the needs to of the residents with responsive behaviors. The ED/DOC verified that the home had not developed all of the above information. [s. 53. (1)]

2. Inspector #542 reviewed a Critical Incident Report (CI) that was submitted to the Director in May 2016, alleging resident to resident abuse. The CI report indicated that resident #007 abused resident #011. The altercation resulted in resident #011 sustaining an injury. The CI report also identified, that a referral to an outside agency for resident #007 would be completed.

Inspector #542 reviewed resident #007's health care record for an eight month period, April 2016 to November 2016, and identified 11 incidents of responsive behaviours. The current care plan available to the direct care team identified that the resident had the potential for abusive behaviour and resisted treatment or care. The care plan did not include any potential triggers to resident #007's responsive behaviours nor did it contain any mention of the resident's specific abusive responsive behaviours.

On November 8, 2016, Inspector #542 interviewed PSW #105 and PSW #106, who indicated that resident #007 exhibited specific responsive behaviours.

On November 9, 2016, Inspector #542 interviewed PSW #114, who indicated that resident #007 had exhibited specific responsive behaivours towards other residents.

On November 14, 2016, Inspector #542 interviewed PSW #115 who indicated that resident #007 exhibited specific responsive behaviours towards staff and other residents.

Inspector #542 interviewed the ED/DOC and the RQM, who stated that a referral was sent to an outside agency; however, there had been no follow up with the agency by the home, in attempt to have an assessment completed for resident #007. The ED/DOC stated that more information should have been located on the care plan with regards to the resident's responsive behaviours. Inspector #542 asked if any changes were made

to resident #007's care plan after the incident occurred. The RQM was unable to locate any archived care plan. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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 have resulted in responsive behaviours, 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, 4. Protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.

WN #4: 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 for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that includes its goals and objectives and relevant policies, procedures, protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Throughout the course of the inspection, Inspectors #542, #543 and #613 reviewed the home's Skin and Wound Care Management protocol (RC-170), Skin and Wound procedure (RC-174) and Falls Prevention (RC-226) policies. The Inspectors identified that the above mentioned policies had not met the requirements under section 30 of the regulation. There was no written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, included protocols for the referral of residents to specialized resources where required.

On November 7, 2016, Inspector #613 interviewed the Executive Director/Director of Care (ED/DOC), who stated that the written description of the Falls Prevention and Management Program was currently a work in progress and was unable to provide a written description of the program to the Inspector.

On November 10, 2016, Inspectors #542 and #543 met with ED/DOC and the Resident Quality Manager (RQM), regarding the home's skin and wound policy/procedure. The Inspectors went through the requirements of the programs with them. They confirmed that the policy on skin and wound was in fact the home's program. The ED/DOC verified that the home's policy had not met the requirements under the legislation and act. [s. 30. (1) 1.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it is based to the Director.

As part of this inspection, Inspector #613 followed up on an outstanding compliance order, where the home was to ensure that all staff members, volunteers, agency staff, private duty caregivers, contracted service providers, the leadership team, and all others who provided care to residents were trained and retrained on zero tolerance of abuse and neglect of residents. This was completed by the home, however, other non-compliance regarding s. 24 was identified during the course of this inspection.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in July 2016, alleging staff to resident abuse. The CI report revealed that PSW #102 had allegedly abused resident #013 during provisions of care in July 2016.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident" last revised May 2016, Policy #: RC-126, indicated all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families are required to immediately report any suspected or known incident of abuse or neglect to the Executive Director/Administrator or designate in charge of the home. The Executive

Director/Administrator would then report to the MOHLTC Director.

Inspector #613 interviewed the ED/DOC on November 4, 2016, who confirmed the incident had actually occurred on another date in July 2016 not on the July 2016 date, as identified on the CI report. The ED/DOC stated that they became aware of the incident on a specific date in July 2016, when PSW #115 had left a written note regarding the alleged incident under the door of the RQM's office. The ED/DOC stated they were unsure why the CI report had been dated incorrectly or why it had been submitted late, and stated that perhaps they had submitted the CI report once the internal investigation had been completed. The ED/DOC confirmed the alleged abuse had not been reported immediately to them nor had they reported to the Director immediately. [s. 24. (1)]

2. Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed the resident #016 had abused resident #017 in October 2016, by touching them inappropriately.

A review of resident #016's health care record revealed that the resident had been involved in another alleged abuse incidents with resident #017, prior to the October 2016 incident, on an earlier date in October 2016, where resident #016 had touched resident #017 inappropriately.

A further review of resident #016's health care record revealed that the resident had been involved in other alleged abuse incidents involving another resident, resident #018.

A review of resident #018's e-notes identified that the resident was upset after an incident in October 2016 when they had been touched inappropriately three times by resident #016 and brought into an occupied room. On another date in October 2016, resident #016 was again witnessed being inappropriate with resident #018 in an area of the home. There was no documentation to identify that each witnessed abuse had been reported to the Director.

During the review of resident #017's health care record, the Inspector noted that the first October 2016 incident of witnessed abuse had not been reported to the Director; only the second October 2016 incident had been reported.

On November 15 and 17, 2016, Inspector #613 interviewed the ED/DOC, who stated they had not reported the incidents that had occurred in October 2016, involving residents #017 and #018 to the Director as they had used the Ministry of Health and

Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse as a guide to determine their decision not to report and could not determine resident #016's intent to abuse the residents due to their cognitive impairment.

The Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse identified that once the licensee becomes aware of alleged, suspected witnessed abuse of a resident and there are reasonable grounds to suspect that abuse has occurred or may occur the licensee is to immediately report suspicion and information to the Director (via CIS memo; required to report after hours pager outside business hours). [s. 24. (1)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 8, 2016, Inspector #613 completed a drug storage observation with RPN #104 while RN #107 was present in the medication room. RN #107 informed the Inspector that when the destruction bin becomes too full, prior to Pharmacy coming in and completing a drug destruction, the controlled substances were taken to the Executive Director/Director of Care's office where they stored the controlled substances in a safe, in their office.

On the same date, Inspector #613 interviewed the ED/DOC, who reported that all controlled substances for destruction were kept in a locked cupboard in their office, but there was no safe. The ED/DOC stated they did not have a key to the cupboard, only had a key to their office and the RQM had a key to the cupboard, but did not have a key to the ED/DOC's office. The ED/DOC confirmed the controlled substances were not locked in a separate double locked stationary cupboard in the locked office. The ED/DOC stated that they had been in conversation with the Pharmacist from Shaw Pharmacy to provide a locked safe to store the controlled substances in the locked cupboards. However, throughout the RQI, Inspector #613 observed the door to the ED/DOC's office open where other Administration staff's work stations were located.

Inspector #613 reviewed the Shaw's Pharmacy – Med - I – Well Services Pharmacy Manual for Cedarwood Lodge. A review of the policy titled, "Safe Storage of Medication" last revised April 1, 2015, Policy No. PHM-032, indicated all narcotics would be kept locked in the narcotic lock box inside the medication cart. Narcotics not kept in the medication cart would be stored in a separate, double locked stationary cupboard within the locked medication room. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: 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 their policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging staff to resident abuse. The CI report revealed that PSW # 102 had allegedly abused resident #013 during the provisions of care in July 2016.

A review of the home's internal investigation of the incident identified that the incident had actually occurred in July 2016; however, it had not been reported to management nor had an internal investigation occurred until a specific date in July 2016. The investigation notes identified that the CI was reported to the Director in July 2016, five days after the incident had occurred and two days after management had become aware of the incident.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident" last revised May 2016, Policy #: RC-126, indicated all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families are required to immediately report any suspected or known incident of abuse or neglect to the Executive Director/Administrator or designate in charge of the home. The Executive Director/Administrator would then report to the MOHLTC Director. The policy also indicated that an investigation would be carried out immediately.

During an interview with the Executive Director/Director of Care (ED/DOC), they confirmed that PSW #115 who had been assisting PSW # 102 with the provisions of care for resident #013 had hand written a note, which was dated for a specific date in July 2016, regarding the incident and had put the note under the door of the RQM's office. The note was not received by the RQM until a specific date in July 2016 and on this date, the note and incident was brought to the ED/DOC's attention. The ED/DOC confirmed that PSW #115 had reported the alleged abuse late and had not followed the home's policy for immediate reporting to the ED/DOC or designate in charge of the home. [s. 20. (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 their policy to promote zero tolerance of abuse and neglect of resident #013 and all other residents is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that was reported to the licensee was immediately investigated.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed the resident #016 had abused resident #017 in October 2016, by touching them inappropriately.

A review of resident #016's health care record revealed that the resident had been involved in another alleged abuse incidents with resident #017, prior to the October 2016

incident, on an earlier date in October 2016, where resident #016 had touched resident #017 inappropriately.

A further review of resident #016's health care record revealed that the resident had been involved in other alleged abuse incidents involving another resident, resident #018.

A review of resident #018's e-notes identified that the resident was upset after an incident in October 2016 when they had been touched inappropriately three times by resident #016 and brought into an unoccupied room. On another date in October 2016, resident #016 was again witnessed being inappropriate with resident #018 in an area of the home.

During the review of resident #017's health care record, the Inspector noted there was no documentation in the e-notes regarding the two October 2016 incidents of abuse, to identify the resident's response to each incident or to identify an immediate investigation had occurred for each incident of alleged, suspected or witnessed incident of abuse. Similar, during the review of resident #018's health care record, the Inspector noted there was no documentation in the e-notes regarding the two October 2016 incidents of abuse, to identify the resident's response to each incident or to identify an immediate investigation had occurred for each incident of alleged, suspected or witnessed incident of abuse

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident" last revised May 2016, Policy #: RC-126, indicated that an investigation will be carried out immediately, initiated by the Executive Director/Director of Care. Anyone aware of or involved in the situation, would write, sign and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.

On November 15 and 17, 2016, Inspector #613 interviewed the ED/DOC, who was unable to provide investigation reports for each incident to the Inspector. They stated that they did not have any incident reports or investigation notes for each incident, rather they had talked to staff in regards to each incident; however, they had not written any notes. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed the resident #016 had abused resident #017 in October 2016, by touching them inappropriately.

A review of resident #016's health care record revealed that the resident had been involved in alleged abuse incidents involving resident #018 on two dates in October 2016.

During the review of resident #018's e-notes identified that the resident was upset after an incident in October 2016 when they had been touched inappropriately three times by resident #016 and brought into an occupied room. On another date in October 2016, resident #016 was again witnessed being inappropriate with resident #018 in an area of the home. The documentation failed to identify that resident #018's substitute decision-maker (SDM) was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

On November 15 and 17, 2016, Inspector #613 interviewed the ED/DOC, who verified that the SDM for resident #018 was not notified of each witnessed abuse incidents at the time of each occurrence.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident" last revised May 2016, Policy #: RC-126, indicated the registered nurse would inform the substitute decision-maker immediately of the alleged abuse if the incident had caused harm, pain, or distress to the resident. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed the resident #016 had abused resident #017 in October 2016, by touching them inappropriately.

A review of resident #016's health care record revealed that the resident had been involved in another alleged abuse incidents with resident #017, prior to the October 2016 incident, on an earlier date in October 2016, where resident #016 had touched resident #017 inappropriately.

During the review of resident #017's health care record, the Inspector noted there was no

documentation in the e-notes notes regarding the October2016 incident of abuse, to identify the resident's response to each incident or to identify that resident #017's substitute decision-maker had been informed of the abuse incident within 12 hours.

On November 15 and 17, 2016, Inspector #613 interviewed the ED/DOC, who verified that the SDM for resident #017 was not notified of the first October 2016 incident until a later date in October 2016, thirteen days later when the second abuse incident occurred.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident" last revised May 2016, Policy #: RC-126, indicated the registered nurse would inform the substitute decision-maker immediately of the alleged abuse if the incident had caused harm, pain, or distress to the resident. All other incidents must be communicated within 12 hours. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #018's substitute decision-maker or any other person specified by the resident is notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that had resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being and resident #017's substitute decision-maker or any other person specified by the resident is notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

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

Findings/Faits saillants :

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

Inspector #542 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report indicated that resident #007 abused resident #011. The altercation resulted in resident #011 sustaining an injury. It was identified on the CI report that resident #007 had insight into what he had done to resident #011.

In May 2016, an Inspection Team Lead (ITL) contacted the home to inquire if the home had notified the police regarding the incident of resident to resident abuse. The ED/DOC stated that they had not contacted the police. On a specific date in May 2016, the Sudbury Service Manager contacted the police regarding the incident of resident to resident abuse. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, included all areas where drugs were stored shall be kept locked at all times, when not in use.

On November 3 and 4, 2016, Inspector #543 observed two medication carts left unattended in the hallway of the resident care area. The carts were observed to be unlocked and there were no staff members in the area at that time.

On November 7, 2016, Inspector #543 observed a medication cart left unattended near the nursing station. The cart was unlocked, and near residents who were sitting at the nursing station. There were no staff members in the area at that time.

On November 15, 2016, Inspector #543 observed a medication cart left unattended near the dining room. The cart was observed to be unlocked and there were no staff members in the area at the time.

Inspector #613 reviewed the Shaw's Pharmacy – Med - I – Well Services Pharmacy Manual for Cedarwood Lodge. A review of the policy titled, "Safe Storage of Medication" last revised April 1, 2015, Policy No. PHM-032, indicated all regularly administered medications would be kept in the medication cart which would be kept locked at all times when it was unattended. The medication cart would be kept locked in the locked medication room when not in use.

On November 8, 2016, Inspector #613 interviewed the ED/DOC, who confirmed that medication carts were to be locked when the medication carts were out of the registered staff's view. As well, the locked medication carts were to be stored in the locked medication/storage room in between medication administration times. [s. 130. 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 steps are taken to ensure the security of the drug supply, shall include all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On November 8, 2016, Inspector #613 completed a drug storage observation with RPN #104. During the drug storage observation, the RPN informed the Inspector that resident #015 had permission to keep a specific medication at their bedside that they self-administered. However, when the Inspector asked the RPN to provide the prescriber's order for self-administration on two different dates, RPN #104 was unable to provide the prescriber's order for self-administration to the Inspector.

A review of resident #015's health care record did not identify that a prescriber had approved the resident to self-administer and keep the medication in their room.

During interviews with RN#107 and RN #111, they both stated they were aware that resident #015 kept the specific medication in their room and self-administered the medication. Both RN's were unable to provide the Inspector with a prescriber's order to demonstrate that the medication had been approved by the prescriber for the resident to self-administer.

On November 9, 2016, Inspector #613 interviewed resident #015, who stated they were permitted to keep the medication at their bedside and self-administer. The resident stated they had the medication at their bedside and had been self-administering the specific medication since their admission, August 2016. Resident #015 informed the Inspector that the doctor did not speak or provide them with approval to self-administer and keep the medication in their room, but rather a staff member had provided them permission. During the interview, the Inspector observed the specific medication lying on

the resident's bed.

The Inspector reviewed the Shaw's Pharmacy – Med - I – Well Services Pharmacy Manual for Cedarwood Lodge. A review of the policy titled, "Resident Self – Administration of Medication" last revised April 1, 2015, Policy No. PHM-033, indicated the self-administration of medications by patients will only be allowed after careful review of medication needs and authorization by the attending physician.

During an interview on November 9, 2016 with the ED/DOC, they stated they were unaware that resident had medication at the bedside and had been self-administering. The ED/DOC confirmed there had been no prescriber's order for approval of resident #015 to self-administer the specific medication or to keep it their bedside. [s. 131. (5)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were dressed appropriately, that was suitable to the time of day and in accordance with their preferences, in their own clean clothing and in appropriate clean footwear.

During the inspection, Inspector #542 observed resident #010 to be dressed inappropriately at a specific time. The resident was dressed in a night shirt with a sheet wrapped around their legs.

On a different day at a specific time, Inspector #542 observed resident #010 with a sleeveless night shirt on and a sheet wrapped around their legs.

Inspector #542 interviewed PSW #109, who indicated that they generally kept resident #010 in their night clothes on their shower days and a shower had been provided after breakfast. Inspector #542 asked PSW #109 if this information was part of resident #010's care plan and the PSW responded that they thought so.

The Inspector reviewed resident #010's care plan that was available to the direct care staff, which identified under the problem heading, "dressing" that resident #010 was to be dressed appropriately for the season and required assistance for dressing. [s. 40.]

WN #14: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of the names of any staff members or other persons who were present at or discovered the incident.

Inspector #613 reviewed a Critical Incident Report that was submitted to the Director alleging staff to resident abuse. Upon completion of the home's internal investigation, the home determined the allegations of abuse were unfounded.

On November 4, 2016, the Inspector interviewed the ED/DOC, who had submitted the CI report to the Director on August 15, 2016. The ED/DOC reviewed the CI report and acknowledged that it did not contain the PSW's name that was involved in the incident [s. 107. (4) 2. ii.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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

Findings/Faits saillants :

1. The licensee has failed to shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee failed to ensure that all assessment, reassessment and

monitoring, including the resident's response were documented.

During the inspection, Inspector #543 observed resident #006 up in their wheelchair with a device applied.

Inspector #543 reviewed resident #006's care plan specifically related to restraints, which indicated the resident required a device while in wheelchair. The resident's care plan directed staff to check the resident hourly and reposition every two hours as per the home's policy.

The Inspector reviewed the home's Restraint Monitoring record for this resident for the months of August, September, October and November, 2016 and identified the following:

August 2016: no hourly checks documented from 1200-1500 hrs and from 1600-2300 hrs,

August 2016: no hourly check documented for 1500 hrs,

September 2016: no hourly check documented for 1300-1400 hrs,

September 2016: no hourly check documented for 1200-1400 hrs,

Three dates in October 2016: no hourly check documented for 1200-1400 hrs,

Two dates in November 2016: no hourly check documented for 1200-1400 hrs,

During the inspection, Inspector #542 observed resident #011 up in their wheelchair with a device applied.

Inspector #542 reviewed resident #011's care plan specifically related to restraints, which indicated the resident required a device while in their wheelchair and that they were at risk for falls. The resident's care plan directed staff to check the resident hourly and reposition every two hours as per the home's policy.

The Inspector reviewed the home's Restraint Monitoring record for this resident for the month of October 2016, and identified the following.

October 2016: no hourly checks documented from 2100-2300 hrs,

October 2016: no hourly checks documented from 2000-2300 hrs

On November 8, 2016, Inspectors #543 and #542 interviewed the ED/DOC, who confirmed that staff should have identified and documented what they had done with the restraints, such as applying, positioning and releasing. Inspector #543 showed the ED/DOC the lack of documentation for resident #006 on the Restraint Monitoring record. The ED/DOC verified that the lack of documentation was unacceptable.

On November 8, 2016, the Inspector interviewed RN #107, who stated that the registered staff were to sign off on the Restraint Monitoring Record every 8 hours. They stated that the purpose of them signing was to ensure the PSWs documented their hourly checks. If there were signatures from the PSWs that were missing, they stated that they were responsible to notify the PSWs to complete the documentation on the sheet.

On November 16, 2016, the Inspector interviewed PSW #121, who stated the PSWs needed to document hourly for each resident who had a restraint, if the resident was repositioned, if the restraint was released and when it was applied. The registered staff were required to document for the resident's use of restraint at the end of each shift. [s. 110. (7) 6.]

2. During the inspection, resident #011 was observed up in their wheelchair with a device applied.

Inspector #542 reviewed resident #011's care plan specifically related to restraints, which indicated the resident required a device restraint while in wheelchair. The resident's care plan directed staff to check the resident hourly and reposition every two hours as per the home's policy and the registered staff would sign the restraint sheet accordingly.

The Inspector reviewed the home's Restraint Monitoring record for this resident for the month of October 2016, and noted that out of a total of 27/93 shifts the registered staff had not documented their evaluation of the need for the restraint. [s. 110. (7) 6.]

3. The licensee has failed to ensure that the documentation included every release of the device and repositioning.

During the inspection, resident #006 was observed up in their wheelchair with a device applied.

Inspector #543 reviewed resident #006's care plan specifically related to restraints, which indicated the resident required a device while in wheelchair. The resident's care plan directed staff to check the resident hourly and reposition every two hours as per the home's policy.

The Inspector reviewed the home's Restraint Monitoring record for resident #006 for the months of August, September, October and November, 2016, which identified that for a total of 84/286 shifts the registered staff had not documented their evaluation of the need for the restraint.

On November 8, 2016, Inspector #543 interviewed the ED/DOC, who confirmed that staff should have identified and documented what they had done with the restraints, such as applying, positioning and releasing. Inspector #543 showed the ED/DOC the lack of documentation for resident #006 on the Restraint Monitoring record. The ED/DOC verified that the lack of documentation was unacceptable.

On November 8, 2016, the Inspector interviewed RN #107, who stated that the registered staff were to sign off on the Restraint Monitoring Record every 8 hours. They stated that the purpose of them signing was to ensure the PSWs were documenting their hourly checks. [s. 110. (7) 7.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:

1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.

2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee has failed to ensure that orientation training was provided to the direct care staff on safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that were relevant to the staff member's responsibilities.

During the inspection, resident #010 was identified as having, areas of altered skin integrity.

On November 7, 2016 at 1100 hours, Inspector #542 observed resident #010 in their wheelchair and their wheelchair device was deflated around their area of altered skin integrity.

On November 7, 2016, Inspector #542 interviewed PSW #102, who stated they were unsure who was responsible for ensuring that resident #010's wheelchair device was properly inflated as the residents would normally tell the staff when something was wrong with their equipment. They also informed the Inspector, that they had not received any training on the specific wheelchair device.

On November 7, 2016, the Inspector interviewed PSW #105 and #106, both verified that they had not received training on the correct use of the equipment.

Inspector #542 interviewed the ED/DOC and the RQM, both confirmed that the home had not provided any training on the safe and correct use of resident #010's wheelchair device. [s. 218. 2.]

Issued on this 24th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), JENNIFER LAURICELLA (542), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2016_395613_0019
Log No. / Registre no:	001035-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 21, 2017
Licensee / Titulaire de permis :	AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC. 130 ELM STREET, SUDBURY, ON, P3C-1T6
LTC Home / Foyer de SLD :	CEDARWOOD LODGE 860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rudy Putton

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

To AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall develop, submit and implement a plan that includes the following:

1. A process to ensure that all physician's orders are followed and when there is a change in a resident's wounds that the Physician (Medical Director) is notified.

2. A process to ensure that staff and others involved in the different aspects of care of residents #005, #010 and #014 and all other residents, collaborate with other members of the care team, including the Medical Director and Physician Assistant to maintain effective communication regarding the status of resident's wounds, so that their assessments are integrated and are consistent with and complement each other.

3. A process to ensure that the home maintains effective communication between the Wound Care Specialist, Physician, Medical Director, Physician Assistant, Nurse Practitioner or any other resources who are part of the interdisciplinary team for each resident.

This plan shall also include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation.

This plan shall be submitted, in writing, to Lisa Moore, Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at SudburySAO.moh@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133. This plan must be received and fully implemented by April 7, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of residents #005, #010 and #014, so that their assessments were integrated and were consistent with and complemented each other.

(A) During the inspection, resident #005 was identified as having a worsening area of altered skin integrity.

Inspector #543 reviewed the resident's care plan which indicated that resident #005 had an area of altered skin integrity. An intervention identified that registered staff were to administer altered skin integrity care as per the physician orders.

A review of resident #005's health care record identified documented physician orders related to the resident's area of altered skin integrity. The physician's orders, dated May 2016 (resident's admission date), indicated, a specific treatment with specific dates to complete. There was no other order in the physician's order sheets to address the altered skin integrity care after May 2016.

On November 4, 2016, Inspector #543 interviewed RN #110, who verified there was an order from resident #005's admission, May 2016, related to altered skin integrity care, and there was no other order in the physician's orders to address the altered skin integrity. They also confirmed that the admission order differed from what care was being done for the altered skin integrity at the time of the inspection.

A review of the resident's electronic progress notes (e-notes) dated, June 2016, indicated that the wound care lead, who was the Executive Director/Director of Care (ED/DOC), had assessed the resident's area of altered skin integrity and changed the treatment orders. The documentation, written by the ED/DOC, identified that there were new orders for the altered skin integrity, to provide a specific treatment.

During an interview with the ED/DOC, they verified that they had changed the physician's admission orders for resident #005's altered skin integrity care in June 2016.

On November 9, 2016, Inspector #543 interviewed the Physician Assistant (PA), who verified that it was the expectation that any change in a resident's altered skin integrity status would be reported to the Medical Director (MD) or Physician Assistant (PA) for further assessment. The PA stated that staff were expected to report to the MD or PA, the need for changes to orders and that staff were not to change the order.

(B) During the inspection, resident #010 was identified to have an urinary intervention.

Inspector #542 completed a health care record review for resident #010. The current care plan indicated that the resident's urinary intervention was to be completed monthly as ordered by the Medical Director. A physician's order, dated May 2016, indicated that the urinary intervention was to be completed at the urology clinic. The Treatment Administration Record (TAR) from June – July 2016 indicated that the urinary intervention was to be completed at the urology clinic. The TAR from August 2016, indicated that the urinary intervention was completed at the home on two dates in August 2016; however, a physician's order was not identified to support the completion.

On November 7, 2016, Inspector #542 interviewed RN #107, who indicated that they had completed resident #010's urinary intervention and the resident no longer required it to be completed at the urology clinic. RN #107 stated there was no order from the Medical Director (MD) to complete the urinary intervention at the home and that they had not consulted or collaborated the MD regarding this completion of the intervention in the home.

(C) During the inspection, resident #010 was identified as having, an area of altered skin integrity.

Inspector #542 reviewed the current care plan for resident #010. It was documented that the resident had areas of altered skin integrity to a specific area. The care plan indicated that resident #010 also had other areas of altered skin integrity.

The Inspector completed a health care record review and reviewed a form titled, "Stage II: Care Plan, Assessment and Treatment Sheet", from February 2016, which identified a specific treatment to be completed on specific dates, that the staff were to complete, this was decided in collaboration with the ED/DOC. There was no physician's order to identify the specific treatment plan. In February 2016, the Physician Assistant wrote an order for a consultation with a wound care specialist for the resident's specific areas of altered skin integrity. The e-notes from March 2016, indicated that resident #010 was assessed by the wound care specialist; however, there was no further documentation regarding the consultation. In May 2016, it was documented on the physician's order sheet that the ED/DOC had written an order for the resident's specific area of altered skin integrity, indicating a specific treatment. It was documented in the e-notes on MED e-care, that the RN on shift had called the ED/DOC to inform

them, that the specific area of altered skin integrity was deteriorating. The ED/DOC had then provided the RN with new orders to start a specific treatment to the areas.

The health record for resident #010 identified a physician's order dated June 2016, that outlined new orders from the wound care specialist and a follow up appointment for July 2016. Inspector #542 was unable to locate any information as to whether resident #010 was seen by the wound care specialist or not in July 2016. The Resident Quality Manager (RQM) reviewed their appointment books and was unable to locate any documentation to support that resident #010 had gone to the follow up appointment. Also, a review of the e-notes in MED e-care did not identify that the resident went to the appointment.

On November 14, 2016, Inspector #542 interviewed the RQM and requested they contact the wound care specialist in an attempt to locate the missing orders or consultation notes.

On November 15, 2016, Inspector #542 was provided with consultation notes from the wound care specialist by the RQM. A consultation note dated March 2016, indicated that the wound care specialist had seen resident #010 and recommended that a specific treatment be completed. A consultation note dated June 2016 indicated that they ordered a specific treatment. Also, a consultation note from June 2016 was provided to the Inspector. It was documented that a specific treatment should be instituted for resident #010's area of altered skin integrity. The Inspector spoke with the RQM who verified that they had not initiated the specific treatment for resident #010's specific area of altered skin integrity care.

On November 16, 2016, Inspectors #542 and #543 interviewed the Physician Assistant (PA), who indicated they were not aware that the wound care specialist had recommended the specific treatment for resident #010's altered skin integrity care in June 2016. Also, they were not aware of other recommendations from another consultation in June with the wound care specialist. The PA stated that the home had changed the orders and written their own direction regarding altered skin integrity treatments on several different occasions without notifying the PA or the Medical Director.

On November 17, 2016, Inspector #542 and #543 interviewed the Medical Director (MD) for the home. The MD indicated that they had not signed the

Medical Directives for Wound Care Protocols. They stated that it was an expectation that the MD or PA be notified when a resident's altered skin integrity had deteriorated. The MD said that they were not aware that some of registered staff were using specific treatments without a physician's order.

(D) Inspector #543 reviewed a complaint that was received by the Director related to concerns with the provision of care provided to resident #014's altered skin integrity care. According to the complaint report, the resident's family felt that had the resident received proper altered skin integrity treatment, resident #014's altered skin integrity would not have worsened.

Inspector #543 reviewed resident #014's health care record which identified that the resident had areas of worsening altered skin integrity.

The Inspector reviewed the resident physician orders and identified the following:

April 2016: Wound Care Protocol for a specific area of altered skin integrity, physician was not notified.

April 2016: Wound Care Protocol for a specific area of altered skin integrity, infected, physician not notified.

April 2016: Specific area of altered skin integrity, Prescriber Order Form in health care record filled out by the ED/DOC, and not signed by the MD or PA. The ED/DOC had informed the Inspector this form was a Medical Directive.

April 2016: Specific area of altered skin integrity, infected, Prescriber Order Form in health care record filled out by the ED/DOC, and not signed by the MD or PA. The ED/DOC had informed the Inspector this form was a Medical Directive.

April 2016: Specific order for a specific area of altered skin integrity, the order was placed on hold by the ED/DOC.

May 2016: Altered skin integrity orders stated to see previous orders, PA wrote a note stating, "that at what point do you want to allow this thing confer resistancy because other measures are being ignored". Specific interventions provided.

May 2016: Order to remind staff to follow order of specific intervention to promote healing of altered skin integrity.

July (no date specified): Wound care specialist commented that they would appreciate that their orders be followed, and that if they needed to be changed, they must be contacted, otherwise seeing them would be a waste of time for both the physician and resident. To continue with previous order.

September 2016: Order to increase nutritional supplement.

On November 8, 2016, Inspectors #542 and #543 interviewed the ED/DOC and RQM to determine who had the authority to change the physician orders related to altered skin integrity care. They both verified that no one other than the physicians and the PA could change orders. Inspectors #542 and #543 brought it to their attention that the orders had been altered by the ED/DOC. The ED/DOC stated they were not sure how that had occurred.

On November 15, 2016, Inspectors #543 and #542 interviewed the PA, who stated that there was a "massive communication failure" between management, the physician and the PA. The PA verified that it had occurred in the past whereby, MD or PA orders had been put on hold or changed by the registered staff. The PA stated it was not an accepted procedure for registered staff to change MD orders, and this should not have occurred. They further indicated that there was an inconsistency with the altered skin integrity assessments, there was a lack of communication between staff to MD or PA when change in altered skin integrity status occurred and that it was very difficult for the MD and PA to locate documentation related to altered skin integrity concerns. The PA also verified that Wound Care Protocols and/or Medical Directives, had not been signed by the MD.

On November 17, 2016, Inspectors #542 and #543 interviewed the Medical Director (MD). The Inspectors showed the MD the two orders written from April 2016. The MD stated that they had not signed those Medical Directives for the Wound Care Protocols. The MD further stated that there were a number of issues with individuals changing orders or writing orders for altered skin integrity. They indicated that if an area of altered skin integrity had deteriorated, that the physician or PA should have been notified and that this was not always done. The physician stated that they were not aware that staff were using the protocols and instituting specific intervention to areas of altered skin integrity and verified

this should not have occurred.

(E) Inspector #542 completed a health care record review for resident #010. A review of their care plan identified, the resident was to receive a specific amount of a nutritional supplement. A review of resident #010's current Medication Administration Record (MAR) did not indicate that the nutritional supplement was being provided to them.

A review of the health care record identified resident #010 was admitted to the hospital in May 2016 and returned to the home in May 2016 with new orders from the hospital. On the MAR from the hospital, there was no record regarding the nutritional supplement.

Inspector #542 interviewed the ED/DOC and the RQM, who both agreed that the registered staff should have reviewed resident #010's MAR that was in place prior to the resident's hospital admission and compared them to the hospital discharge orders to ensure no medications were missed. They then should have reviewed the medications with the Medical Director.

An assessment by the Registered Dietitian (RD) #108 in May 2016 for resident #010 indicated that the current nutritional plan was to be continued including the nutritional supplement due to the resident's areas of altered skin integrity; however, this was not identified on the MAR.

The decision to issue a compliance order was based on the severity, which was determined to be actual harm or risk to the health and safety of residents #005, #010 and #014 and all other residents. Although, the home had no previous noncompliance history with this provision in the legislation, the scope was determined to be widespread with in the home.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1. Develop and implement a process to ensure that for residents #008, #010 and #014 and all residents that the care set out in the plan of care is provided as specified in the plan.

2. Develop and implement a processes to ensure the Medical Director and Physician Assistant's orders are followed and not changed by registered staff.

3. Ensure audits are done on the above processes and records kept.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was provided to the residents as specified in the plan, specifically for resident #008, resident #010 and resident #014.

(A) During the inspection, resident #010 was identified as having areas of altered skin integrity.

Inspector #542 completed a health care record review for resident #010. A physician's order, dated September 2016, indicated that resident #010 was to be up in their wheelchair no longer than a specific amount of time. The most current care plan available to the direct care staff indicated that the resident must be placed back to bed at certain times of the day. It was also documented that staff were to use a specific device for positioning in bed.

On November 8, 2016, Inspector #542 observed resident #010 to be up in their

wheelchair at 1840 hours. Inspector #542 interviewed RN #107, who indicated that the staff had transferred the resident out of bed into their chair, at a specific time and the resident had been up longer than the specified amount of time indicated in their care plan and physician's order.

On November 9, 2016 at 1850 hours, Inspector #542 observed resident up in their wheelchair. The Inspector interviewed PSW #106, who verified that resident #010 was put in their wheelchair during the day shift. The resident had been in their wheelchair for a longer amount of time then specified in their care plan and ordered by the physician.

On November 14, 2016 at 1030 hours, resident #010 was observed up in their wheelchair. Inspector #542 interviewed PSW #114, who stated that resident #010 did not typically go back to bed at certain times of the day and sometimes they stayed up in their wheelchair for an extended period of time. PSW #114 indicated that when resident #010 was repositioned in bed, they would use a device underneath the resident to slide them up in bed. This was not the same device that was indicated in the resident's care plan.

(B) Inspector #543 reviewed a complaint that was received by the Director related to concerns with the provision of care provided to resident #014's altered skin integrity care. According to the complaint report, the resident's family felt that had the resident received proper altered skin integrity treatment, resident #014's areas of altered skin integrity would not have worsened.

Inspector #543 reviewed resident #014's care plan related to skin integrity which identified that the resident had areas of altered skin integrity. The interventions included, but were not limited to, altered skin integrity care as per physician orders, to ensure a specific intervention to promote healing to areas of altered skin integrity and nutritional supplement.

Through a health care record review, the Inspector identified that physician altered skin integrity orders had been altered, the altered skin integrity order had been placed on hold by the ED/DOC and the ED/DOC had completed a Prescribed Order Form that had not been signed by the Medical Director. Registered staff were implementing Wound Care Protocols and not notifying the MD. The resident at times did not have the specific intervention completed and there were missed doses of the nutritional supplement.

On November 15, 2016, Inspectors #543 and #542 interviewed the PA, who stated that it had occurred in the past whereby, the MD or PA orders had been put on hold or changed by the registered staff. The PA stated it was not an accepted procedure for registered staff to change MD orders, and should not be occurring. They further indicated that there was an inconsistency with the altered skin integrity assessments.

On November 17, 2016, the Inspector interviewed the RQM, who confirmed that registered staff had not followed the plan of care for administering the nutritional supplement with the medication pass. The RQM stated if the MAR indicated "not given" and there was no progress note attached for a reason of not given, then the nutritional supplement had not been given by the registered staff.

(C) During the inspection, resident #008 was identified for requiring further inspection regarding not having a plan to address their BMI (Body Mass Index) status.

Inspector #543 reviewed the resident's care plan which identified that resident #008 was at a nutritional risk. The care plan indicated that the resident was to receive a specific diet with specific texture and fluids and was to be seated at a specific table.

The Inspector reviewed the Dietary Master List that identified that resident #008 required a different specific diet and was to be seated at a different specific table. Staff referred to the Dietary Master List to provide the resident with, but not limited to the appropriate diet type and texture, serving instructions and seating location in the dining room.

On November 9, 10, 15 and 16, 2016, Inspector #543 observed the resident seated at a specific table in the dining room, different from the table specified in their care plan.

On November 16, 2016, the Inspector interviewed the Dietary Services Manager #116, who verified that the Dietary Master List indicated the resident was to receive a different specific diet and was to be seated at a different specific table. They confirmed that the resident's care plan identified that the resident was ordered a specific diet and was to be seated at a specific table.

On November 17, 2016, the Dietary Services Manager #116 verified that the

resident was supposed to receive a specific diet as per the resident's care plan and that the Dietary Master List contained the incorrect information related to resident #008's specific diet type as per the needs and preferences of the resident.

The decision to issue a compliance order was based on the potential for actual harm to residents #008, #010 and #014's health and safety. The scope was determined to be a pattern and the home continues to have on-going non compliance in this area of the legislation. There was a history of previous noncompliance identified during the following inspections:

-A voluntary plan of correction (VPC) was issued during Critical Incident System Inspection #2016_339617_0019 served to the home on June 27, 2016;

-A voluntary plan of correction (VPC) was issued during Resident Quality Inspection #2016_281542_003 served to the home on February 24, 2016;

-A voluntary plan of correction (VPC) was issued during Critical Incident System Inspection #2015_281542_0021 served to the home on December 22, 2015;

-A voluntary plan of correction (VPC) was issued during Complaint Inspection #2015_339617_0018 served to the home on September 28, 2015;

-A voluntary plan of correction (VPC) was issued during Compliant Inspection #281542_0013 served to the home on August 14, 2015.

(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance under s. 19 (1) of the LTCHA, to ensure that all residents are protected from abuse by anyone and shall ensure that all residents are not neglected by the licensee or staff. The plan is to include but not be limited to:

1. Developing a system to ensure the home's internal investigations related to every alleged, suspected or witnessed incident of abuse of a resident by anyone, is immediately and thoroughly investigated and written documentation is maintained in a separate file.

2. Ensure that when every alleged, suspected or witnessed incident of abuse of a resident by anyone, is reported that no resident has any unnecessary contact with the potential perpetrator, until the home has completed their investigation and the plans of care of the residents involved are immediately updated to prevent recurrence.

This plan shall also include specified time frames for the development and implementation and identify the staff member(s) responsible for the implementation.

This plan shall be submitted, in writing, to Lisa Moore, Long-Term Care Homes Inspector, Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury ON P3E 6A5, by email at SudburySAO.moh@ontario.ca. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133. This plan must be received and fully implemented by March 7, 2017.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and has failed to ensure that residents were not neglected by the licensee or staff.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed that resident #016 abused resident #017 in October 2016, by touching them inappropriately.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

During an interview on November 17, 2016, the ED/DOC verified that all staff and management were aware of resident #016's previous history of inappropriate abusive behaviours of touching other residents, prior to the October 2016 incident involving resident #017.

A review of resident #016's health care record revealed that the resident had been involved in another alleged abuse incident with resident #017, prior to the October 2016 incident, on an earlier date in October 2016, where resident #016 had inappropriately touched resident #017.

A further review of resident #016's health care record revealed that the resident had been involved in other alleged abuse incidents involving another resident, resident #018. The e-notes on MED e-care identified that in October 2016, resident #016 was witnessed touching another resident #018 inappropriately three times, as well as telling resident #018 to meet them in their room and later on the same date, wheeled resident #018 in their wheelchair into a vacant room. The e-notes identified that resident #018 was upset about the incident. On another date in October 2016, resident #016 was witnessed by RPN #104 being inappropriate again with resident #018 in an area of the home.

A review of resident #018's e-notes identified that the resident was upset after an incident in October 2016 when they had been touched inappropriately three times by resident #016 and brought into a unoccupied room. On another date in October 2016, resident #016 was again witnessed being inappropriate with resident #018 in an area of the home. There was no documentation in the e-

notes on MED e-care to identify whether each incident was consensual or non-consensual, if an immediate investigation had occurred for each incident, if staff immediately reported to the Executive Director/Administrator or designate in charge of the home, if resident's SDM was notified of the incidents or the outcomes of the investigation, or that police had been contacted. The Inspector noted, each incident of witnessed abuse had not been reported to the Director.

During the review of resident #017's health care record, the Inspector noted there was no documentation in the e-notes regarding the October 2016 incident, to identify that the incident was consensual or non-consensual, if an immediate investigation had occurred, the resident's response to the incident or to identify that resident #017's Substitute Decision-Maker (SDM) was notified of the incident or the outcomes of the investigation, or that police had been contacted for the two October 2016 incidents of abuse. The Inspector noted that the first October 2016 incident of witnessed abuse had not been reported to the Director, only the second October 2016 incident had been reported.

Other inappropriate incidents involving resident #016 documented in the e-notes on MED e-care were as follows;

-October 2016. Found touching an unidentified resident inappropriately

-October 2016. Found with another resident in their room, touching one another

The Inspector noted that resident #016's care plan had not been revised or updated until a specific date in October 2016, after resident #016 had acted in a inappropriate manner on several occasions toward residents #017 and #018. The home's physician was not updated about resident #016's behaviours until a specific date in October 2016, after resident #016 had acted in a inappropriate manner toward residents #017 and #018. The ED/DOC was unable to verify to the Inspector if each incident where resident #016 acted in a specific nature toward residents #017 and #018 had been consensual or not as they stated all residents had cognitive impairments. The ED/DOC also stated that no assessment was done to determine if any of the incidents where resident #016 acted in a specific nature toward residents #017 and #018 were consensual.

There was no close monitoring of resident #016 on the unit, to ensure they were not in close proximity or left unattended with other residents during specific time frames, until a later date in October 2016, when 15 minute checks were

implemented, even though all staff were aware of resident #016's previous behaviours. The CI report identified that a referral to a specific agency would be made; however, this was not done.

On November 15 and 17, 2016, Inspector #613 interviewed the Executive Director/Director of Care, who stated that all staff, management, registered staff (RNs and RPNs) and personal support workers (PSWs) were aware of resident #016's previous history of inappropriate behaviours. The ED/DOC was unable to provide investigation reports for each incident to the Inspector. They stated that they did not have any incident reports or investigation notes for each incident, rather they had talked to staff in regards to each incident. The ED/DOC stated they had not reported the incidents in October 2016, involving residents #017 and #018 to the Director as they had used the Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse as a guide to determine their decision not to report and could not determine resident #016's intent to abuse the residents due to their cognitive impairment.

A review of The Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse, identified that once the licensee becomes aware of alleged, suspected witnessed abuse of a resident and there are reasonable grounds to suspect that abuse has occurred or may occur the licensee is to immediately report suspicion and information to the Director (via CIS memo; required to report after hours pager outside business hours).

During interviews with the ED/DOC, they verified that the SDM's for residents #017 and #018 were not notified of each witnessed abuse incidents at the time of the occurrence. The ED/DOC confirmed that resident #017's SDM was notified of the first October 2016 incident on a later date in October 2016, thirteen days later when the second abuse incident occurred. The ED/DOC stated they were unaware that resident #018 had been upset following the October 2016 incident as RPN #119, who had documented in the e-notes on MED e-care had not reported that to them that resident #018 had been upset.

The decision to issue a compliance order was based on the actual harm and risk to residents #017 and #018's health and safety and potentially all other residents' in the home. The scope was determined to be a pattern and the home continues to have on-going non compliance in this area of the legislation. There was a history of previous noncompliance identified during the following inspection:

-A voluntary plan of correction (VPC) was issued during Complaint Inspection #2015_395613_0021 served to the home on July 7, 2016.
(613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure for residents #007 and all other residents demonstrating responsive behaviours:

1. Actions are taken to respond to the needs of the resident, ensuring assessments, reassessments and interventions and the resident's responses to interventions are documented in their plan of care.

2. Ensure behavioural triggers are identified on all residents' care plans that demonstrate responsive behaviours.

3. A referral for resident #007 is made to a specific outside agency and the home remains in direct contact with the agency to ensure assessments and follow up direction is provided to all staff.

Grounds / Motifs :

1. Inspector #542 reviewed a Critical Incident Report (CI) that was submitted to the Director in May 2016, alleging resident to resident abuse. The CI report indicated that resident #007 abused resident #011. The altercation resulted in resident #011 sustaining an injury. The CI report also identified, that a referral to an outside agency for resident #007 would be completed.

Inspector #542 reviewed resident #007's health care record for an eight month

period, April 2016 to November 2016, and identified 11 incidents of responsive behaviours. The current care plan available to the direct care team identified that the resident had the potential for abusive behaviour and resisted treatment or care. The care plan did not include any potential triggers to resident #007's responsive behaviours nor did it contain any mention of the resident's specific abusive responsive behaviours.

On November 8, 2016, Inspector #542 interviewed PSW #105 and PSW #106, who indicated that resident #007 exhibited specific responsive behaviours.

On November 9, 2016, Inspector #542 interviewed PSW #114, who indicated that resident #007 had exhibited specific responsive behaivours towards other residents.

On November 14, 2016, Inspector #542 interviewed PSW #115 who indicated that resident #007 exhibited specific responsive behaviours towards staff and other residents.

Inspector #542 interviewed the ED/DOC and the RQM, who stated that a referral was sent to an outside agency; however, there had been no follow up with the agency by the home, in attempt to have an assessment completed for resident #007. The ED/DOC stated that more information should have been located on the care plan with regards to the resident's responsive behaviours. Inspector #542 asked if any changes were made to resident #007's care plan after the incident occurred. The RQM was unable to locate any archived care plan.

The decision to issue a compliance order was based on the actual harm to resident #011 and risk to other residents' health and safety. The scope was determined to be a pattern and the home continues to have on-going noncompliance identified during the following inspection:

-A voluntary plan of correction (VPC) was issued during the Compliant Inspection #2016_395613_0021 served to the home on December 22, 2015. (542)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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:

1. Develop a written description of the skin and wound program and the falls prevention 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 were required.

2. Implement the programs and provide training to all registered nurses, registered practical nurses and personal support workers on the home's skin and wound and falls prevention programs. Training records of who was trained on what date and content of the training programs will be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there was a written description of the program that includes its goals and objectives and relevant policies, procedures, protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Throughout the course of the inspection, Inspectors #542, #543 and #613 reviewed the home's Skin and Wound Care Management protocol (RC-170), Skin and Wound procedure (RC-174) and Falls Prevention (RC-226) policies. The Inspectors identified that the above mentioned policies had not met the requirements under section 30 of the regulation. There was no written description of the program that included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes, included protocols for the referral of residents to specialized resources where required.

On November 7, 2016, Inspector #613 interviewed the Executive Director/Director of Care (ED/DOC), who stated that the written description of the Falls Prevention and Management Program was currently a work in progress and was unable to provide a written description of the program to the Inspector.

On November 10, 2016, Inspectors #542 and #543 met with ED/DOC and the Resident Quality Manager (RQM), regarding the home's skin and wound policy/procedure. The Inspectors went through the requirements of the programs with them. They confirmed that the policy on skin and wound was in fact the home's program. The ED/DOC verified that the home's policy had not met the requirements under the legislation and act.

The decision to issue a compliance order was based on the potential for actual harm and risk to the resident's health and safety of the home. The home had no previous noncompliance identified; however, the scope was considered to be a pattern. (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2017

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2016_463616_0013, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall;

1. Ensure that any person who has reasonable grounds to suspect that abuse of resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it is based to the Director.

As part of this inspection, Inspector #613 followed up on an outstanding compliance order, where the home was to ensure that all staff members, volunteers, agency staff, private duty caregivers, contracted service providers, the leadership team, and all others who provided care to residents were trained and retrained on zero tolerance of abuse and neglect of residents. This was

completed by the home, however, other non-compliance regarding s. 24 was identified during the course of this inspection.

Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director in July 2016, alleging staff to resident abuse. The CI report revealed that PSW #102 had allegedly abused resident #013 during provisions of care in July 2016.

A review of the home's policy titled, "Prevention of Abuse & Neglect of a Resident" last revised May 2016, Policy #: RC-126, indicated all employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents and families are required to immediately report any suspected or known incident of abuse or neglect to the Executive Director/Administrator or designate in charge of the home. The Executive Director/Administrator would then report to the MOHLTC Director.

Inspector #613 interviewed the ED/DOC on November 4, 2016, who confirmed the incident had actually occurred on another date in July 2016 not on the July 2016 date, as identified on the CI report. The ED/DOC stated that they became aware of the incident on a specific date in July 2016, when PSW #115 had left a written note regarding the alleged incident under the door of the RQM's office. The ED/DOC stated they were unsure why the CI report had been dated incorrectly or why it had been submitted late, and stated that perhaps they had submitted the CI report once the internal investigation had been completed. The ED/DOC confirmed the alleged abuse had not been reported immediately to them nor had they reported to the Director immediately. [s. 24. (1)]

2. Inspector #613 reviewed a Critical Incident Report (CI) that was submitted to the Director alleging resident to resident abuse. The CI report revealed the resident #016 had abused resident #017 in October 2016, by touching them inappropriately.

A review of resident #016's health care record revealed that the resident had been involved in another alleged abuse incidents with resident #017, prior to the October 2016 incident, on an earlier date in October 2016, where resident #016 had touched resident #017 inappropriately.

A further review of resident #016's health care record revealed that the resident had been involved in other alleged abuse incidents involving another resident,

resident #018.

A review of resident #018's e-notes identified that the resident was upset after an incident in October 2016 when they had been touched inappropriately three times by resident #016 and brought into an occupied room. On another date in October 2016, resident #016 was again witnessed being inappropriate with resident #018 in an area of the home. There was no documentation to identify that each witnessed abuse had been reported to the Director.

During the review of resident #017's health care record, the Inspector noted that the first October 2016 incident of witnessed abuse had not been reported to the Director; only the second October 2016 incident had been reported.

On November 15 and 17, 2016, Inspector #613 interviewed the ED/DOC, who stated they had not reported the incidents that had occurred in October 2016, involving residents #017 and #018 to the Director as they had used the Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse as a guide to determine their decision not to report and could not determine resident #016's intent to abuse the residents due to their cognitive impairment.

The Ministry of Health and Long Term-Care (MOHLTC) Decision Tree Licensee Reporting of Abuse identified that once the licensee becomes aware of alleged, suspected witnessed abuse of a resident and there are reasonable grounds to suspect that sexual abuse has occurred or may occur the licensee is to immediately report suspicion and information to the Director (via CIS memo; required to report after hours pager outside business hours).

The decision to issue a compliance order was based on the potential for actual harm to resident #013, #017 and #018 and all other residents' health and safety. The scope was determined to be a pattern and the home continues to have ongoing non-compliance in this area of the legislation. There was a history of previous noncompliance identified during the following inspections:

-A compliance order (CO) was issued during Complaint Inspection #2016_463616_0013 served to the home on July 7, 2016;

-A voluntary plan of correction (VPC) was issued during Critical Incident System Inspection #2015_395613_0022 served to the home on February 4,

2016;

-A written notification (WN) was issued during Critical Incident System Inspection #2015_281542_0021 served to the home on December 22, 2015.

(613)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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