Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2019	2019_807644_0016	012712-19, 017270-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Bay Ridges
900 Sandy Beach Road PICKERING ON L1W 1Z4

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

ANGIEM KING (644)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 5, 6, 7, 8, 12, 13, 14, and 15, 2019.

The following intakes related to complaints were inspected:
-Log #012712-19 related to the prevention of abuse and neglect,
-Log #017270-19 related to the prevention of abuse and neglect.

This inspection was conducted concurrently with CI inspection #2019_626501_0025.
The following Critical Incident System intake(s) related to the same issue alleged abuse was completed during this Complaint inspection:
Log # 020832-19, related to the prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Business Manager, physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), recreation aide, residents and substitute decision-makers (SDMs).

During the course of inspection, the inspectors(s) conducted observations of personal care, staff and resident interactions, reviewed health records, home's complaint and Critical Incidents (CI) investigation records, call bell records, video surveillance footage and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of

his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 has the right not to be neglected by the staff.

The home submitted Critical Incident System (CIS) reports on specified dates, related to allegations resident #004 called for help and the personal support worker (PSW) took the call bell, turned it off and walked away, and resident was not provided assistance with Activities of Daily Livings (ADLs), PSW #128 did not return to the resident and the resident did not receive assistance until near the end of the shift.

An interview with resident #004, stated they remembered when they had used their call bell to ask for assistance with a specific ADL but the PSW did not come back.
The resident did not recall the specific date when this occurred.

An interview with resident #004's substitute decision maker (SDM) revealed resident #004 informed them that staff would answer their call bell, ask them what they wanted and leave. SDM would call the nurse and they said the PSW forget and they accepted this.

A review of the home's investigation notes indicated the home completed their investigation related to the incidents. The home found evidence that PSWs #125, #128 and RPN #133 had committed an act of neglect upon resident #004. Further review of the investigations revealed PSWs #125, #128 and RPN #133 received disciplines for neglect of resident's rights. A review of the PSWs and RPN personnel files indicated there was no previous disciplines in the last two years for neglect.

A review of the Minimum Data Set (MDS) assessment on a specified date, indicated resident #004 has cognitive impairment. According to the plan of care on a specified

date, the resident required specific interventions, uses walker to ambulate and resident was identified to need specified assistance by one staff to transfer, and two staff for specific ADL care, if staff unable to provide assistance immediately staff are to provide reassurance and time frame of their return to complete task.

Record review of an identified report indicated resident #004 used their call bell on specified dates and times during a two-month period.

An interview with PSW #127 indicated they were informed by RPN #133 that they had answered resident #004's call bell and they were requesting assistance with ADL care. PSW #127 further indicated they had provided RPN #133 the resident's ADL interventions and assumed RPN #133 had assisted resident #004.

An interview with RPN #133 indicated they had answered resident #004's call bell on a specified shift, on a specified date and they had informed PSW #127 resident #004's request for assistance with a specific ADL. RPN #133 further indicated they had gone back to the resident and told resident #004 that the PSW would be in shortly and they had assumed that PSW #127 had assisted the resident.

An interview with PSW #128 acknowledged on a specified date, they had answered resident #004's call bell, assisted the resident to sit up in bed and applied resident's footwear but when they were going to assist resident #004 with the specified ADL the resident had stated they were not ready. PSW #128 further stated they had informed the resident to call when they were ready however when the resident did not call, they failed to go back and check on resident #004.

An interview with PSW #127 indicated they were informed on a specified date, when they went to provide specific ADL care at a specified time to resident #004 and was told that they had called and the PSW did not come back.

An interview with ADOC #103 and DOC #104 acknowledged that based on the home's investigation, the alleged neglect of resident #004 by PSW #125, PSW #128 and RPN # 133 was founded. The staff failed to return and assist resident #004 with a specific ADL care timely manner, thus constituting neglect.

The home failed to ensure resident #004's right not to be neglected. [s. 3. (1)]

Issued on this 26th day of November, 2019

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

Original report signed by the inspector.