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 16, 2017	2016_268604_0015	018486-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

BRADFORD VALLEY
2656 6th Line Bradford ON L3Z 3H5

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

SHIHANA RUMZI (604), JENNIFER BROWN (647), SIMAR KAUR (654), THERESA BERDOE-YOUNG (596), VALERIE JOHNSTON (202)

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): June 20, 22, 23, 24, 27, 28, 29, 30, 2016, July 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 2016, and August 8 and 9, 2016.

The following Critical Incident System (CIS) report intakes where inspected concurrently along with the home's Resident Quality Inspection (RQI):

Alleged abuse: Log #014282-15, Log #011816-16, Log #009521-16, Log # 016216-16, Log #019300-16
Alleged neglect: Log #008815-16, Log #020584-16, Log #019600-16
Alleged financial abuse: Log # 215556-16 and Log #014274-16
Responsive behaviours resident to resident: Log #018635-15 and Log #021828-16
Falls: Log #013729-16 and Log #019187-16
The home's emergency processes related to fire: Log #020703-16

The following intakes where related to complaints:
Log #018163-16 – Complaint related to request for coroner's investigation.
Log #010673-16 – Improper care
Log #007907-16 – Facility refusing visitations, closed as inquiry
Log #009719-16 – related to over medication
Log # 001816-16 – letter related to moving LTC homes

Follow-up Order:
Log #017433-16 – Follow up to order s.19 (1) – Abuse and neglect
Log #017375-16 – Follow up order s. 6 (7) – Plan of care
Log #017431-16 – Follow up order s. 6 (10) – Plan of care
Log #018489-16 – Follow up Order s. 131. (1) – Medication administration

During the course of the inspection, the inspector(s) spoke with the Executive Director, Interim Executive Director, Director of Care (DOC), Associate Director of Care(s) (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Manager (EM), Dietary Services Supervisor (DSS), Director of Dietary Services (DDS), Dietary Team Member (DTM), Office Manager (OF), Restorative Care Aide(s) (RCA), Physiotherapy Assistant (PTA), Recreational Program Team (RPT), Behavioural Support Service (BSS), Arjo Huntleigh Equipment Consultant, Residents, Substitute Decision Makers (SDMs), Private Care Givers (PCG), Presidents of Residents and Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service, medication administration, staff and resident interactions, and provision of care. Inspectors conducted documentation review of resident's electronic documentation, reviewed home's complaints and critical incident logs, staff training records, meeting minutes of Residents and Family Council, relevant policies and procedures at the home, and home's order logs. Interviews were conducted with residents, SDM's, staff and management of the

home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **6 VPC(s)**
- **4 CO(s)**
- **0 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. 131. (1)	CO #001	2015_168202_0018	604
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2016_391603_0006	596
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2016_391603_0006	604
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_391603_0005	647

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

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a. The home submitted an identified Critical Incident System report (CIS) report on an identified date, indicating there had been an altercation where resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same identified location of the home. Minutes later resident #041 re-approached resident #042 and attempted to remove the garment again causing a tug of war which then resulted in resident #042 sustained an injury needing to be transferred to hospital.

A review of resident #041's clinical records revealed that the resident had been identified with identified responsive behaviour on admission.

A review of the progress notes for resident #041, indicated that on the day of the incident, the resident had been observed early morning to be exhibiting identified responsive behaviours towards a staff member and co-resident.

An interview with RPN #124 who had worked the day of the incident reported that the resident had been expressing an identified responsive behaviour throughout the day. The RPN further indicated that at he/she called the physician for consideration of a Form 1 due to the resident's increased responsive behaviours. The RPN further indicated that the physician directed him/her to administer the when necessary (PRN) medication that had been currently in place to manage resident #041's identified responsive behavior prior to transferring the resident to hospital.

The progress notes indicated that resident #041's behaviours continued to escalate on an identified date, resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same area of the home. Minutes later resident #041 re-approached resident #042 and attempted to remove the garment causing a tug of war which then resulted in resident #042 falling and sustaining injuries.

A review of the Medication Administration Record (MAR) on the identified date, indicated that resident did have an existing medication order for an identified medication to be given daily as needed to resident #041.

When inspector asked why RPN #124 did not administer the identified medication as specified in the resident's plan of care, the RPN stated that he/she did not know or understand the uses of the PRN medications and therefore did not provide the care to resident #041 as specified in the plan of care.

b. On an identified date, family member of resident #026 approached Inspector #604 and indicated the following:

On an identified date, the family member arrived to spend the day with resident #026 and the staff got resident #026 up that morning. The family member indicated he/she requested a PSW to change and put the resident in to bed, as the resident was very tired. The family member re-approached the same PSW and requested he /she assist resident #026 back into bed. The family member indicated he/she then approached the RPN on an identified shift and requested staff assist resident #026 with continence care and transfer the resident into bed for a rest.

The family member stated he/she observed the resident’s brief to be soaked, long with the pants and wheel chair seat to be wet with urine. The family member indicated the

evening PSW's who's names he/she was unaware, were very apologetic.

An interview with the family member revealed he/she was unable to recall the name of the staff or provide a description of the staff member he/she approached to get resident #026 changed and put to bed after lunch.

The home submitted an identified CIS report on an identified date, indicating the following:
Resident #026's primary care staff on the day shift was PSW #146. An interview with PSW #146 confirmed he/she provided care to the resident and got resident up with the assistance of PSW #147. The PSW indicated he/she is aware of resident's plan of care and indicated the resident is to be put to bed during the day. The PSW indicated the last time he/she checked on resident was when he/she brought the resident's morning snack as family was with resident and anticipated family would ask for assistance when needed. The PSW confirmed he/she did not check or provide any care to resident #026 after an identified date, that morning, and did not see the resident prior to the end of his/her shift.

Interview conducted with RPN #108 confirmed he/she worked on an identified date and shift. The RPN indicated resident #026 had family with him/her the whole day and PSW #146 was the resident's primary PSW. The RPN indicated resident #026's plan of care directs staff to put resident back to bed after meals for a rest and was unaware that resident was not put to bed on the identified day till the next shift when he/she reviewed shift report.

Interview with PSW #147 confirmed he/she assisted PSW#146 with resident #026's morning care and transfer on the date indicated and was not asked for further assistance throughout the shift by PSW#146. The PSW further indicated he/she was not approached by family asking to assist with putting resident #026 back to bed.

Interview with RPN #148 indicated family member approached him/her at the start of his/her evening shift and stated he/she had requested resident #026 to be put to bed twice by day staff and resident was not put to bed. RPN stated he/she immediately got PSW#149 and #150 to put resident back to bed and went to assess resident #026's status. The RPN indicated resident #026 had not been provided care as set out in the plan of care.

An interview conducted with PSW #149 indicated RPN #148 asked him/her and PSW

#150 to transfer resident #026 to bed immediately. PSW #149 stated it was unusual for resident #026 to not be in bed, when he/she was asked to put resident in bed. PSW #149 stated he/she went to the resident's room with PSW #150, observed resident to be sitting in his/her assistive device. PSW stated once transferred to bed the two PSW's changed resident and resident was lightly incontinent.

An interview with PSW#150 confirmed he/she assisted PSW#149 in transferring and changing resident #026 on the identified date. The PSW indicated the resident had not been provided care as set out in the plan of care.

Interview with Associate Director of Care (ADOC) #106 confirmed the above incident had occurred and home had started an investigation. The ADOC indicated resident #026 was not checked after PSW #146 provided the morning snack and did not provide the care set in the plan of care.

The home is being served an order as resident #042 sustained injury and care set out in the plan of care was not provided to resident #026 and resident #042 as specified in the plan.

The home has ongoing non-compliance with legislation, s. 6 (7) which is as follows:
1) March 7, 2016, Inspection Number 2016_391603_0005, VPC's related to Responsive Behaviours, Fall Prevention, and Personal Support Services.

2) May 18, 2016, Inspection Number 2016_391603_0005, CO related to Responsive Behaviours, Fall Prevention, and Personal Support Services.

3) October 22, 2015, Inspection Number 2015_356618_0018, WN related to Personal Support Services.

4) April 22, 2014, Inspection Number 2014_168202_0011, VPC's related to Responsive Behaviours and Personal Support Services.

5) November 27, 2013, Inspection Number 2013_168202_0063, VPC related to Responsive Behviours.

The severity of the non-compliance and the severity of harm and risk is actual.

The scope of the non-compliance is a pattern.

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During stage one of the Resident Quality Inspection (RQI), identified care are was triggered for resident #019.

One month record review of the resident's identified care assessment and interview with RPN #108 indicated that resident had an identified care need.

Record review of Nurse Practitioners (NP) order on an identified date revealed care to be carried out every two days and review of the resident's care records indicated no sign off the care provided on an identified date.

Interview with RPN #108 revealed that he/she provided the care as identified to resident #019's and missed signing off when the care was completed.

3. The home submitted an identified CIS report on an identified date to the Ministry of Health & Long Term Care (MOHLTC) involving a resident to resident altercation between resident #040 and #039.

Documentation review of resident #040's progress notes for an identified date indicated up until the above mentioned incident, revealed the resident was exhibiting identified responsive behaviours.

A review of the physician's orders for resident #040 directed staff to commence monitoring on an identified date. Review of the resident's monitoring on the home's Dementia Observation System (DOS) form revealed missing documentation, the day after the altercation between resident #40 and #39 on an identified shift.

An interview with PSW #184 revealed he/she worked on an identified shift and date, and forgot to document resident #040's monitoring on the DOS monitoring form.

An interview with ADOC #141 confirmed that the PSW's are expected to document on the DOS form on an identified date, since resident #40 had been exhibiting responsive behaviours throughout the month including an altercation with resident #039 on an identified date.

Interviews with ADOC #141 and the DOC revealed that registered staff is expected to initiate the DOS documentation with PSWs documenting on the form after every resident to resident altercation and any new responsive behaviours ongoing until the monitoring is no longer needed.

4. The home submitted an identified CIS report on an identified date, to MOHLTC Director indicating resident to resident alleged abuse/ neglect.

Record review of resident #039's physician order revealed the monitoring of resident's behaviours was to commence after the altercation with resident #040 on an identified date.

Record review of resident #039's identified assessments revealed resident was already on monitoring prior to the altercation with resident #040 on an identified date. Record review of the resident's form revealed that there were missing signatures on identified dates and identified shifts.

Interviews conducted with PSW #161, #184 and ADOC #106 confirmed the provision of care was not documented for resident #039 for the identified dates.

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

During stage one of the Resident Quality Inspection (RQI), an Minimum Data Set (MDS) triggered for management for resident #010's identified care area.

Record review of resident #010's current care plan and kardex directed staff to transfer resident to toilet using identified resident equipment and two staff. Review of resident's physiotherapist assessment, recommended assistance from one staff for resident mobility needs.

Interview with RPN #139 revealed that resident #010's care needs have changed since return from hospital. RPN #139 reported that he/she mobilized the resident with PSW #138 on an identified date, using a two person pivot transfer, and the resident's care plan has not been reviewed and revised to reflect the resident's current transfer status.

Interview with PT #143 confirmed that he/she had not received any further referrals to

reassess resident's transfer status since last assessment. The resident's care plan had not been revised to reflect the change in transfer status upon return from hospital. Record review of the resident's clinical record revealed a change in transfer status upon return from hospital and a new referral for PT to assess resident for transfers on an identified date.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was protected from neglect by the licensee or staff in the home.

Neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents. O. Reg. 79/10, s. 5.

a. On an identified date, family member of resident #026 approached Inspector #604 and indicated the following:

On an identified date, the family member arrived to spend the day with resident #026 and the staff got resident #026 up that morning. The family member indicated he/she requested a PSW to change and put the resident in to bed, as the resident was very tired. The family member re-approached the same PSW and requested he /she assist resident #026 back into bed. The family member indicated he/she then approached the

RPN on an identified shift and requested staff assist resident #026 with continence care and transfer the resident into bed for a rest.

The family member stated he/she observed the resident's brief to be soaked, long with the pants and wheel chair seat to be wet with urine. The family member indicated the evening PSW's who's names he/she was unaware, were very apologetic.

An interview with the family member revealed he/she was unable to recall the name of the staff or provide a description of the staff member he/she approached to get resident #026 changed and put to bed after lunch.

The home submitted an identified CIS report on an identified, indicating the following: Resident #026's primary care staff on the day shift was PSW #146. An interview with PSW #146 confirmed he/she provided care to the resident and got resident up with the assistance of PSW #147. The PSW indicated he/she is aware of resident's plan of care and indicated the resident is to be put to bed during the day. The PSW indicated the last time he/she checked on resident was when he/she brought the resident's morning snack as family was with resident and anticipated family would ask for assistance when needed. The PSW confirmed he/she did not check or provide any care to resident #026 after an identified date, that morning, and did not see the resident prior to the end of his/her shift.

Interview conducted with RPN #108 confirmed he/she worked on an identified date and shift. The RPN indicated resident #026 had family with him/her the whole day and PSW #146 was the resident's primary PSW. The RPN indicated resident #026's plan of care directs staff to put resident back to bed after lunch for a rest and was unaware that resident was not put to bed on the identified day till the next shift when he/she reviewed the shift report on his/her next shift.

Interview with PSW #147 confirmed he/she assisted PSW#146 with resident #026's morning care and transfer on the date indicated and was not asked for further assistance throughout the shift by PSW#146. The PSW further indicated he/she was not approached by family asking to assist with putting resident #026 back to bed.

Interview with RPN #148 indicated family member approached him/her at the start of his/her identified shift and stated he/she had requested resident #026 to be put to bed twice by day staff and resident was not put to bed. RPN stated he/she immediately got PSW#149 and #150 to put resident back to bed and went to assess resident #026's

status. The RPN indicated the incident constituted neglect as resident #026 was not put to bed or changed until the evening shift and care was not provided as per plan of care.

An interview conducted with PSW #149 indicated RPN #148 asked him/her and PSW #150 to transfer resident #026 to bed immediately. PSW #149 stated it was unusual for resident #026 to not be in bed. PSW #149 stated he/she went to resident's room with PSW #150, observed resident to be sitting in his/her wheel chair, did not see signs of incontinence.

An interview with PSW#150 confirmed he/she assisted PSW#149 in transferring and changing resident #026 on the identified date. The PSW identified that the incident goes against the Resident's Bill of Rights as the care plan was not followed for resident #026.

Interview with Associate Director of Care (ADOC) #106 confirmed the above incident had occurred and home had started an investigation. The ADOC indicated resident #026 was not checked after PSW #146 provided the morning snack and indicated resident #026's care needs where neglected.

b. The home submitted an identified CIS report on an identified date, to the MOHLTC that indicated alleged misuse or misappropriation of funds involving resident #051.

Record review of the home's investigation notes revealed that a written complaint was submitted to the Director of Care (DOC) by resident #051's Substitute Decision Maker (SDM) for care and finances indicating there were two cheques cashed from the resident's personal bank account by a former PSW #141, on two identified dates in 2016.

Review of the home's CIS and an interview conducted with the DOC revealed as of an identified date, PSW#141 was no longer employed at the home.

Record review of the home's investigation notes revealed a photocopy of two-cashed cheques from resident #051's personal account by PSW #141, on two identified dates.

An interview conducted with resident #051 indicated that he/she could recall the incident indicated above as a police officer visited the resident regarding the incident. The resident could not recall the specific details of the incident.

An interview with resident #051's SDM for care and finances revealed that he/she

identified the two cashed cheques on an identified month, monthly statement of resident #051's personal bank account. A personal cheque was cashed from the resident's personal account to PSW #141 on another identified date.The SDM also reported that there was another cheque cashed a few days prior to the first cheque, for an identified amount of money.

An interview with PSW #141 revealed that he/she stated he/she couldn't recall the incident and denied misuse or misappropriation of resident #051's money.

Interviews with the ADOC and the DOC indicated that the home's investigation determined the cheques were written and signed in the same handwriting as PSW #141's handwriting. The DOC indicated that the home ended their investigation, as the police department initiated an investigation and PSW #141 had resigned before the incident was reported to the home by the POA.

The home is being served an order as the two incidents of abuse inspected had direct impact on the identified residents above.

The home has ongoing non-compliance with legislation, under LTCHA, 2007,. O. Reg 79/10.
s. 19.:

1) March 7, 2016, Inspection Report 2016_391603_0006, CO related to Prevention of Abuse, Neglect and Retaliation.

The severity of the non-compliance and the severity of harm and risk is actual as resident #026 was not provided care as set of out in plan of care and resident #051's money was misused or misappropriation by an identified home staff member.

The scope of the non-compliance is a pattern.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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 a written record was kept related to the evaluation of the responsive behaviour program that included the following: date of the evaluation and the date of the changes were implemented.

Record review of home's annual evaluation of the responsive behaviour program for 2015, and interview with ADOC#115 revealed that the date of evaluation and the date that the changes were implemented, were not documented in the evaluation.

2. The licensee has failed to ensure that, for each resident demonstrating responsive

behaviours strategies were developed and implemented to respond to these behaviours, where possible.

The home submitted an identified CIS report on an identified date, indicating there had been an altercation where resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same identified location of the home. Minutes later resident #041 re- approached resident #042 and attempted to remove the garment again causing a tug of war which then resulted in resident #042 sustained an injury needing to be transferred to hospital.

The home subsequently submitted an identified CIS report, indicating that there had been an altercation where resident #041 approached resident #043 in an identified location of the home and struck him/her with an identified object.

A review of resident #041's clinical records revealed that the resident had been identified behaviour on admission and revealed multiple documented incidents of an identified responsive behaviour.

Interviews with RPNs #119 and #134, PSWs #101, #104, #120, and #121 indicated that resident #041 has exhibited identified responsive behaviours toward residents and staff. The staff further indicated that the resident is often unable to understand what is being said to him/her and an identified responsive behaviours will escalate if individuals raise their voices at him/her. RPN #134 revealed that he/she continues to care for the resident, does not feel safe doing so and feels the residents continue to be at risk of harm. PSW #120 revealed that it is difficult to monitor resident #041 at all times and stated that there are no developed strategies and interventions to respond to the above mentioned behaviors.

The above mentioned staff further indicated that both residents and staff had been subject to resident #041's identified responsive behaviours from the time of resident's admission. Staff indicated that it has been difficult to manage resident #041's responsive behaviors and are frustrated with the lack of developed strategies and interventions that would assist in minimizing the responsive behaviors.

Resident #041's written plan of care identified the resident's responsive behaviours, with no further responsive behaviors identified. The progress notes indicated that resident #041 was sent to hospital on specialist assessment on an identified date, two days after

the above mentioned incident whereby resident #042 sustained a injuries following an altercation with resident #041. A further review of the written plan of care for resident #041 revealed that there had been only one addition to his/her plan of care following his/her return to the home on an identified date, after the specialist assessment.

A review of the clinical records revealed that the physician ordered a Behavioral Support Service Mobile Support Team (BSO) referral on an identified day. Upon further record review inspector was unable to locate any further correspondence related to the BSO referral.

Interviews with DOC, ADOC #106 and RPN #124 confirmed that a referral to the BSO had been processed, however, at the time of the interview neither staff were aware of the location, recommendations or strategies documented by the BSO team. Within one hour the DOC had retrieved the BSO recommendations.

A review of the Behavior Support Plan on an identified date provided the home with 16 written recommendations to manager resident #041's responsive behaviours. A summary of the recommendations.

An interview with the ADOC confirmed that the strategies provided by the BSO on an identified date, had not been assessed nor developed and utilized in resident #041's plan of care.

An interview with the DOC indicated that residents' identified with responsive behaviors are discussed at the monthly Resident Safety and Risk Management Committee meetings. The DOC further indicated that the meetings are intended to develop and implement strategies with the direct care staff on how to manage the aggressive behaviors of residents that pose a risk to co-residents and staff.

The meeting minutes reviewed for a two month period, from the Resident Safety and Risk Management Committee Minutes revealed that resident #041 had been mentioned in four months of minutes and the plan was to conduct monthly meetings and track incidents. On an identified month, the meeting minutes identified resident #041 as being unwell and to revisit his/her care the following meeting.

Interviews with the DOC and the ADOC indicated that resident #041 had been identified with responsive behaviors that had been exhibited toward residents and staff. Both the DOC and the ADOC further confirmed that there had not been any strategies developed

or implemented to respond to resident #041's responsive behaviors, as the 16 recommendations from the BSO team was not communicated by the home to the direct care staff who provided care to resident #041.

The home is being served an order as the inspectors inspected two incidents of responsive behaviours for resident #041 with direct impact to the residents in the home.

The home does not have any previous non-compliance with r. 53. (4).

The severity of the non-compliance and the severity of harm and risk is actual as resident sustained an identified injury.

The scope of the non-compliance is isolated.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a

result of a resident's behavior, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The home submitted an identified CIS report on an identified date, indicating there had been an altercation where resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same identified location of the home. Minutes later resident #041 re- approached resident #042 and attempted to remove the garment again causing a tug of war which then resulted in resident #042 sustained an injury needing to be transferred to hospital.

The home subsequently submitted an identified CIS report indicating that there had been an altercation where resident #041 approached resident #043 in an identified location of the home and struck him/her with an identified object.

A review of the census record for resident #041 revealed that he/she had been admitted to the home on an identified date to an identified home area, then relocated to another home area shortly after, then once again relocated to another home area shortly after the last relocation. The plan of care for resident #041 identified the resident to have responsive behaviors which have been exhibited towards staff.

A clinical review of the progress notes for an identified period of time, revealed multiple documented incidents where residents and staff had been at risk of harm or had been harmed during interactions with resident # 041.

A review of the progress notes for 13 months, revealed 15 incidents involving resident #041.

Interviews conducted with RPN's #119 and #134, PSW's #101, #104, #120, and #121 indicated that resident #041 has exhibited identified responsive behaviours towards residents and staff, with identified targets and will escalate. The staff further indicated that the resident is often unable to understand what is being said to him/her and the identified responsive behaviours will increase if individuals raise their voices at him/her. RPN #134 revealed that he/she continues to care for the resident, does not feel safe doing so and feels the residents on the unit continue to be at risk of harm. PSW #120 revealed that it is difficult to monitor resident #041 at all times and stated that other staff and residents are at risk of being harmed due to his/her unpredictable responsive behaviors.

The above mentioned staff further indicated that both residents and staff had been subject to resident #041's identified responsive behaviours from the time of resident's admission. Staff indicated that it has been difficult to manage resident #041's identified responsive behvaiours behaviors and are frustrated with the lack of developed strategies and interventions that would assist in minimizing potential altercations that have the ability to harm residents and staff.

A review of the clinical records revealed that the physician ordered a BSO referral on an identified date. Upon further record review the inspector was unable to locate any further correspondence related to the BSO referral which would have included an assessment and or recommendations.

Interviews with the DOC, ADOC #106 and RPN #124 confirmed a referral to the BSO had been processed on an identified date, however, at the time of the interview neither staff were aware of the location, recommendations or strategies documented by the BSO team. Within one hour, the DOC had retrieved the BSO recommendations.

A review of the Behavior Support Plan, provided the home with sixteen written recommendations that would assist staff in responding to resident #041's responsive behaviors.

An interview with ADOC #141 confirmed the mentioned strategies provided by the BSO on an identified date, had not been assessed nor developed and utilized in resident #041's plan of care.

An interview with the DOC indicated that resident's identified with responsive behaviors are discussed at the monthly Resident Safety and Risk Management Committee (RSRM) meetings. The DOC further indicated that the meetings are intended to develop and implement strategies with the direct care staff on how to manage the identified responsive behaviors of residents that potentially put co- residents and staff at risk.

The meeting minutes reviewed for an identified period of time from the RSRM minutes revealed that resident #041 had been mentioned on four of the meeting minutes and the plan was to conduct monthly meetings and track incidents. The meeting minutes for an identified month identified resident #041 as being unwell and to revisit his/her care the following meeting.

The DOC confirmed that resident #041 had not been discussed at any of the RSRM meetings and should have been as he/she posed a risk to others. The DOC further confirmed that procedures and interventions have not been developed or implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #041's responsive behaviors.

The home is being served an order as the licensee had not developed or implemented procedures and interventions to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The home has ongoing non-compliance with r. 55. (a), which is as follows:

1) November 27, 2013, Inspection number 2013_168202_0063, CO related to Responsive Behaviours

The severity of the non-compliance and the severity of harm and risk was actual harm. The scope of the non-compliance is isolated.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with 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:
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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly fed in a manner consistent with his or her care needs was fully respected and promoted.

The home submitted an identified CIS report on an identified date, to the MOHLTC indicating alleged staff to resident neglect.

Interview with resident #053's Substitute Decision Maker (SDM) revealed on an identified date, he/she received a call from resident #053 complaining he/she did not receive anything for breakfast that morning. The SDM indicated that the resident had requested toast and tea in his/her room from the day staff on the date indicated, as he/ she was not feeling well to have breakfast in the dining room.

An interview with resident #053 revealed that he/she requested to have tea and toast in his/her room as he/she was not feeling well on the date indicated for breakfast and his/her request was not met.

Interviews with PSW #175 and #181 confirmed they worked day shift on an identified date, and did not provide the resident #053 with any toast during the day shift.

Interview with RPN# 182 revealed that on an identified date, resident #053 complained he/she did not receive toast as per her/his request. The RPN #182 stated he/she informed PSW #183 of resident's request and told him/her to follow up with resident.

An interview with PSW #183 confirmed that he/she did not provide the resident with toast and indicated that as resident #053 was not in his/her assignment he/she assumed that resident's primary care provider who was PSW #175 had followed-up on residents breakfast request.

Interview with the DOC confirmed that resident #053's request for toast for breakfast was not met and resident #053 was not properly fed in a manner consistent with his or her care needs.

Record review of home's investigation notes revealed that staff #175 and #181 received discipline, related to failure to adhere with Resident Bill of rights.

2. The licensee has failed to ensure that every resident has the right to 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.

On an identified date, on an identified location of the home the inspector observed a medication cart to be parked outside an identified location of the home with no registered staff in the area. There where residents in the area of the medication cart ambulating in wheel chairs and walkers. The Inspector observed the Electronic Medication Administration Record (E-MAR) screen was open to resident #029's medication profile.

An interview with RPN #154 confirmed the E-MAR screen displayed resident #029's medication profile. The RPN stated resident #029's medication profile was not protected from passersby and further stated the home's expectation is that the E-MAR screen be locked when not in use.

3. On July 26, 2016, on an identified location of the home , the inspector observed a medication cart to be parked in the corridor in an identified location of the home with the E-MAR screen open and the medication cart to be unattended displaying a resident's personal health information with family members walking by.

Interview with RPN#198 confirmed that the E-MAR screen should be closed when unattended by a registered staff, and he/she should not have left the E-MAR screen open displaying a resident's personal health information when the medication cart was left unattended.

4. On an identified date, on an identified location of the home he/she inspector observed a medication cart to be parked in the corridor in an identified location of the home with the E-MAR screen left open and unattended displaying a resident's personal health information with residents passing by.

RPN #198 arrived from the dining room and apologized confirming the E-MAR screen should be closed when unattended and he/she should not have left it open displaying a resident's personal health information when the cart was unattended.

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 resident's right to be properly fed in a manner consistent with his or her care needs was fully respected and promoted,
-that every resident has the right to 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, to be implemented voluntarily.

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:
a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
b) complied with.

On an identified date, during stage one, the inspector conducted resident room observations for his/her resident assignment on an identified floor of the home. The inspector observed the call bell lights outside five identified rooms were visible however; was not audible to the inspector in five identified rooms on an identified floor.

Interviews conducted with PSW #103 and #104 confirmed the call bells where not audible when rung. The PSWs indicated each PSW on the identified floor had a cell phone to which the call bells would ring to. The PSWs further indicated that out of the three cell phones only one was functioning and the PSW whose cell phone worked is off the floor on break with her cell phone.

Further interview with PSW #103 indicated the cell phones had not been functioning for approximately a month. The PSW showed the inspector one cell phone, which was located in the nursing station which did not turn on. The PSW #103 further indicated he/she is unaware of the location of the second cell phone.

Interview with PSW #104 indicated his/her cell phone was the only cell phone which functioned and indicated it has been approximately a month the two other cell phones had not been functioning.

Home's policy titled "Work Order Requisitions", policy number V-A-10.10 with a revision date of January 2015 directs staff under policy to:
1) Complete a requisition with a full description of work requested.
2) Ensure all requested information has been entered into the requisition.
3) Forward all requisitions to the Maintenance Office (only applies to manual form)
4) Request emergency repairs verbally and follow up with an electronic requisition.

Interview with the Registered Practical Nurses (RPN) #102 confirmed the call bells where not audible. The RPN indicated he/she returned to work on May 6, 2016, and noticed the PSW cell phones where not functioning. The RPN stated the home's policy was that staff complete a computerized maintenance request for any equipment which is broken or malfunctioning or speak to the manager verbally. The RPN further indicated he/she did not send a maintenance request or speak to management as he/she assumed a maintenance request for the PSW cell phones had already been carried out. The RPN placed a maintenance request on the computer during the interview.

An interview with the ADOC #106 confirmed the call bells where not audible and was unaware of the PSW cell phones on an identified home are were not functioning. The ADOC #106 indicated the Environmental Services Manager (ESM) looks after the equipment in the home including the PSW cell phones.

An interview with the ESM #105 indicated he/she was unaware the PSW cell phones where not functioning on an identified home are and indicated staff are expected to complete a computerized maintenance work order and staff did not follow home's policy.

2. The home submitted an identified CIS report on an identified date, to the MOHLTC related to an emergency and fire in the home. The CIS report indicated a PSW noticed smoke through a window of a door leading to an identified stairwell on an identified floor at an approximate time and the staff did not activate the pull station.

An interview conducted with PSW #159 indicated he/she worked on the identified floor and as he/she was transporting a resident down the long hall he/she smelt a burning smell like a cable burning. The PSW indicated he/she opened the door to an identified stairwell and observed a small amount of smoke. The PSW further indicated he/she closed the door to the stairwell and went to get his/her nurse and confirmed he/she did not activate the fire alarm as per home's policy.

Home's policy "Code Red – Fire & Emergency Management Plan –LTC", policy number

XVIII-C-10.00, directs staff to follow the "REACT" process. The process directs the staff that discovers the fire to first remove residents and visitors from danger – remain calm, then ensure doors are closed, as you leave the fire area, if safe to do so and activate the fire alarm system at the nearest fire alarm pull station.

Interview conducted with RN #189 indicated he/she was working on the identified floor and PSW #159 came and informed him/her of the concern related to a smell of smoke in an identified area. The RN indicated he/she went to the identified area and smelt a strong foul smell of burnt rubber and the air looked dusty. The RN continued by saying he/she called the evening ADOC related to the smell and evacuated the resident's in the hall past the fire doors. The RN further indicated looking back, he/she should have pulled the fire alarm as it is home's policy to follow the REACT process.

Interviews conducted with evening Charge RN #132 and evening ADOC #141 both confirmed a smell of smoke and the ADOC indicated he/she saw scant amounts of smoke in the identified stairwell. Both staff members indicated the fire department arrived and pulled the fire alarm immediately and brought a fan to the identified area to clear the smell from the stairwell to the outside of the home thorough the exit door. RN #132 and ADOC #141 indicated they should have pulled the fire alarm as per home's policy but did not.

Interview with the home's ESM indicated staff are educated on "REACT", the home's policy directs staff to pull the fire alarm when suspecting a fire or signs of a fire. The ESM confirmed staff did not pull the fire alarm as per home's "REACT" policy and the fire alarm was pulled by the fire department upon arrival. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and
b) complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system used sound to alert staff, and was properly calibrated so that the level of sound is audible to staff.

On an identified date, during stage one, the inspector conducted resident room observations for his/her resident assignment on an identified home area. The inspector observed the call bell lights outside five identified rooms were visible however; was not audible to the inspector.

Interviews conducted with PSW #103 and #104 confirmed the call bell's where not audible to the staff when rung. The PSW's indicated each PSW on the identified area carry a cell phone to which the call bells would ring to indicating the room number. The PSW's further indicated out of the three phones only one was functioning.

An interview with the RPN #102 confirmed the call bells where not audible to the staff. The RPN indicated he/she did not inform the ESM nor has he/she placed a maintenance request on the computer to have the PSW phones tested to ensure staff are able to hear the call bells when rung.

An interview with ADOC #106 confirmed the call bells where not audible when rung.

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 resident-staff communication and response system used sound to alert staff, and was properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secured and locked.

On an identified date and home area, the inspector observed a grey care cart to be parked outside the shower room. On top of the care cart, the inspector observed two prescription creams for resident #027 and #028, no staff where noted to be in the hall .

The inspector saw the nursing student down the hall and asked to speak to the nurse, RPN #108 arrived and stated PSW staff are allowed to apply prescription creams and ointments are to return the prescription creams back to the nursing station after use. The RPN indicated leaving the prescription creams out in the open posed a risk for wandering residents on the unit and removed the prescription creams off the care cart and indicated he/she would lock them in the medication room.

2. On an identified date and home area, the inspector observed a medication cart to be parked outside the dining room with no registered staff in the area, there where residents in the area of the medication cart ambulating in wheel chairs and walkers. The lock on the medication cart was observed to be sticking out and the inspector was able to open the medication cart drawers.

An interview with RPN #154 confirmed the medication cart was unlocked, which posed a risk to residents nearby and further stated the home's expectation is that the medication cart be locked when not in use.

3. On an identified date and home are the inspector observed a medication cart to be stored outside the dining room with no registered staff in the area and observed two residents near the medication cart ambulating with their walker. The lock on the medication cart was observed to be out, the inspector was able to open the medication cart drawers. The RPN #100 arrived from the hall several minutes later.

An interview with RPN #100 confirmed the medication cart was unlocked and posed a risk to residents nearby. The RPN indicated he/she had to attend to a resident down the hall and forgot to lock the medication cart. The RPN further stated the home's expectation is that the medication cart be locked when not in use.

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 drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #9: 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 has been approved by the prescriber in consultation with the resident.

On an identified date, the inspector carried out observations for resident #021 in his/her room. The resident was found in his/her room sitting on the bed, taking a medication, the inspector inquired from the resident what he/she was taking and the resident indicated he/she takes identified over the counter medication each day. The inspector further inquired as to where the resident got the medication from and the resident proceeded to open his/her night stand next to his/her bed and gave inspector a bottle with a green cap. The bottle identified the medication and dose with an expiration date. When asked where the resident got the medication from, the resident indicated a family member had provided the medication.

The home follows Medical Pharmacies policy "Self-Administration of Medication" policy 5 -5, date 01/14. The policy indicates: Self-administration of medications by a resident is permitted when specifically ordered by the physician who, with input from the nursing team, determines that the resident is capable of self-administering his/her own medication. Their medications are stored in a secure area, inaccessible to other

residents. Procedures direct staff to: 1) Prescriber and nursing team assesses resident for their capacity to self-administer their own medication and complete a "Self-Administration Assessment Form, 2) Prescriber writes a medication order including the direction "may self-administer.

RPN #102 was informed of the observation by the inspector and was brought to the resident's room by the inspector. Resident opened his/her night stand draw and the inspector observed resident had another green cap bottle in the drawer. The second bottle was a different medication with a label identifying its name and dose at which point the resident indicated he/she takes when needed as the home gives him/her the same medication. Both bottles were removed by the RPN.

An interview with RPN #102 indicated he/she was unaware resident #21 was self-administering two medications and the home's policy is that no resident self-administers medication unless assessed by the physician and an order was obtained. The RPN confirmed there was no self-administration order for the resident for the identified medication found in the residents' room.

Interviews with the ADOC #106 indicated home was unaware resident #21 was self-administering medications and confirmed there was no self-administration order for the resident and the home's policy is to assess if the resident is cognitive enough to self-administer medication, obtain a doctor's order, and the resident has to have a key to his/her nightstand to lock medication.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents.

During stage one of the Resident Quality Inspection (RQI), Hospitalization and Change in condition Inspection Protocal (IP) triggered for resident #018.

Record review of resident #018's health records dated on an identified date, confirmed the resident had a heath diagnosis, and review of the physician's orders indicated an order for medication which is to be administered once daily for three days.

An interview with RN #130 revealed that he/she did not record resident #018's symptoms when he/she worked on an identified shift, and should have.

Interview with RN #132 revealed that he/she did not record resident #018's health symptoms when he/she worked on the evening on two identified dates.

Interview with the DOC confirmed registered staff are expected to document residents' health symptoms on every shift, the above mentioned registered staff did not document residents' health symptoms.

2. During stage one of the RQI, hospitalization and change in condition, triggered for resident #010.

Record review of resident #010's progress notes revealed resident returned back to the home from hospital on an identified date, related to an identified health concern. Resident developed showed symptoms on an identified date, and further assessments were carried out. The assessment results, confirmed a health condition diagnosis. Record review of resident #010's assessment results confirmed that the resident had developed a new health condition.

Record review of resident #010's physician's orders and interview with RPN #131, revealed that resident #010 was on medication, with a further medication therapy orders for an identified period of time. Record review of resident #010's progress notes revealed no record of the resident's health assessment on an identified date and shift.

Interview with RPN #126 revealed that he/she worked on an identified date, and was aware of resident #010's health status, and did not record resident's health assessments.

An interview with the DOC confirmed the home's expectation is that registered staff document on every shift regarding resident's health status.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that staff on every shift recorded symptoms of infection in residents, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Record review of resident #019's clinical record revealed the resident currently had a health concern. PSW #113 and RPN #108 reported that the health concern was discovered three to four months ago.

A review of resident #019's weekly assessments revealed an assessment was completed for the health concern on an identified date, and another assessment not completed until 18 days later. After the assessment of the resident's initial health assessment was carried out on an identified date, a weekly assessment was not carried out.

Interview with RPN #121 confirmed that he/she did not complete resident #019's weekly assessment, when he/she worked on the identified dates, nor did he/she complete the weekly assessment scheduled for an identified month.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products based on their individual assessed needs.

During stage one of the RQI, personal care needs was triggered for resident #010.

Record review of resident #010's progress notes indicated the resident returned to the home from hospital on an identified date. Prior to the resident's hospitalization he/she was independent with care needs. Review of the home's resident profile worksheet on an identified date, indicated that resident #010 wore an incontinent product.

Record review of resident #010's current care plan and kardex revealed that resident should have an identified product for incontinence.
On an identified date, the inspector observed resident #010 wearing an identified product and an interview with PSW #138 revealed that he/she assisted another staff to change and put the product on the resident as there were no the identified product available when he/she arrived at the start of his/her day shift. PSW #138 reported that he/she had to borrowed identified incontinent products from another unit, for his/her other residents.

Interview with PSW #138 revealed that all sizes of incontinent products are not always available, especially on an identified date when the new stock is expected to arrive later in that day. The PSW also reported that there was a shortage of incontinent supplies the previous Tuesday.

Interview with PSW #118 revealed that at times they are short of incontinent products for residents and have to borrow from other floors, ask the nurse, or use what's available.

Interview with ADOC #141 confirmed that staff may run short of particular sizes and types of product when staff do not use the correct incontinent products for residents, according to the "Resident Profile" worksheets that he/she updates regularly. The ADOC further reported that he/she had been on vacation for the past two weeks and he/she is the only one who updates the worksheets.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff at the home had received training on the long term care home's policy to promote zero tolerance of abuse and neglect of residents, as required by this section.

The home's compliance plan related to a compliance order #002, left during inspection # 2016_391603_0006, was served to the home on May 18, 2016, indicated that all staff will be retrained on the home's policy to promote zero tolerance of abuse and neglect of residents by June 15, 2016.

During the follow-up inspection which started on June 23, 2016, record review of staff training records and interview with the DOC revealed that 15 staff still had not received training on the home's policy to promote zero tolerance of abuse and neglect of residents.

The home is not compliant with compliance order #002 of inspection #2016_391603_006.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Record review of the home's annual prevention of abuse and neglect program revealed that an annual evaluation was not completed to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents in 2015.

Interview with the DOC confirmed that an evaluation was not completed to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents in 2015.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home submitted an identified CIS report on an identified date, to the MOHLTC and amended the CIS report was submitted by the home two days later indicating alleged misuse or misappropriation of resident #010's money.

Record review of resident #010's progress notes and interview with resident #010's SDM #129 revealed that he/she lodged a verbal complaint to the home on an identified date approximately three months prior, regarding the misuse and misappropriation of resident #010's funds in 2015.

Record review of resident #010's profile revealed the resident's two SDM's share responsibility for care and finance.

Record review of the home's investigation notes revealed a follow-up email to the initial verbal complaint was submitted to ADOC #115 by resident #010's SDM on the date of which the CIS report had been submitted to the MOH, inquiring of the progress and response of the above mentioned concern.

An interview with the ADOC #115 revealed that he/she called resident #010's SDM three months prior with the initial concern, to review the concern after the home had received the complaint.

Interview with resident #010's SDM #129 and SDM #140 revealed that the home responded to their concern three months after the concern was raised only after SDM #140 sent a written concern through an email when the CIS report had been submitted to the MOH.

Interview with the DOC and Executive Director (ED) confirmed the home responded back to SDM #140 when the CIS had been submitted to the MOH, and the DOC further confirmed that a response to the identified resident's POA's concern had not been provided within 10 business days.

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

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Issued on this 21st 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) :	SHIHANA RUMZI (604), JENNIFER BROWN (647), SIMAR KAUR (654), THERESA BERDOE-YOUNG (596), VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2016_268604_0015
Log No. / Registre no:	018486-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 16, 2017
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	BRADFORD VALLEY 2656 6th Line, Bradford, ON, L3Z-3H5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LUANNE CAMPEAU

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 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. (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 :

Within one week of receiving this order, the home shall provide a plan to the inspector on February 24, 2017, the plan shall include:

1)On how the home will ensure that the set plan of care will be provided for the residents.

2)Ways the home will ensure the set plan of care will be reviewed by staff providing direct care to the residents.

3) Ways the home will educate registered staff in identifying medication orders that are to be administered on an as needed bases.

The plan shall be submitted to shihana.rumzi@ontario.ca. within one week of receipt of this order.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a. The home submitted an identified Critical Incident System report (CIS) report on an identified date, indicating there had been an altercation where resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same identified location of the home. Minutes later resident #041 re- approached resident #042 and attempted to remove the garment again causing a tug of war which then resulted in resident #042 sustained an injury needing to be

transferred to hospital.

A review of resident #041's clinical records revealed that the resident had been identified with identified responsive behaviour on admission.

A review of the progress notes for resident #041, indicated that on the day of the incident, the resident had been observed early morning to be exhibiting identified responsive behaviours towards a staff member and co-resident.

An interview with RPN #124 who had worked the day of the incident reported that the resident had been expressing an identified responsive behaviour throughout the day. The RPN further indicated that at he/she called the physician for consideration of a Form 1 due to the resident's increased responsive behaviours. The RPN further indicated that the physician directed him/her to administer the when necessary (PRN) medication that had been currently in place to manage resident #041's identified responsive behavior prior to transferring the resident to hospital.

The progress notes indicated that resident #041's behaviours continued to escalate on an identified date, resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same area of the home. Minutes later resident #041 re-approached resident #042 and attempted to remove the garment causing a tug of war which then resulted in resident #042 falling and sustaining injuries.

A review of the Medication Administration Record (MAR) on the identified date, indicated that resident did have an existing medication order for an identified medication to be given daily as needed to resident #041.

When inspector asked why RPN #124 did not administer the identified medication as specified in the resident's plan of care, the RPN stated that he/she did not know or understand the uses of the PRN medications and therefore did not provide the care to resident #041 as specified in the plan of care.

b. On an identified date, family member of resident #026 approached Inspector #604 and indicated the following:

On an identified date, the family member arrived to spend the day with resident #026 and the staff got resident #026 up that morning. The family member indicated he/she requested a PSW to change and put the resident in to bed, as the resident was very tired. The family member re-approached the same PSW and requested he /she assist resident #026 back into bed. The family member indicated he/she then approached the RPN on an identified shift and requested staff assist resident #026 with continence care and transfer the resident into bed for a rest.

The family member stated he/she observed the resident's brief to be soaked, long with the pants and wheel chair seat to be wet with urine. The family member indicated the evening PSW's who's names he/she was unaware, were very apologetic.

An interview with the family member revealed he/she was unable to recall the name of the staff or provide a description of the staff member he/she approached to get resident #026 changed and put to bed after lunch.

The home submitted an identified CIS report on an identified date, indicating the following:
Resident #026's primary care staff on the day shift was PSW #146. An interview with PSW #146 confirmed he/she provided care to the resident and got resident up with the assistance of PSW #147. The PSW indicated he/she is aware of resident's plan of care and indicated the resident is to be put to bed during the day. The PSW indicated the last time he/she checked on resident was when he/she brought the resident's morning snack as family was with resident and anticipated family would ask for assistance when needed. The PSW confirmed he/she did not check or provide any care to resident #026 after an identified date, that morning, and did not see the resident prior to the end of his/her shift.

Interview conducted with RPN #108 confirmed he/she worked on an identified date and shift. The RPN indicated resident #026 had family with him/her the whole day and PSW #146 was the resident's primary PSW. The RPN indicated resident #026's plan of care directs staff to put resident back to bed after meals for a rest and was unaware that resident was not put to bed on the identified day till the next shift when he/she reviewed shift report.

Interview with PSW #147 confirmed he/she assisted PSW#146 with resident #026's morning care and transfer on the date indicated and was not asked for

further assistance throughout the shift by PSW#146. The PSW further indicated he/she was not approached by family asking to assist with putting resident #026 back to bed.

Interview with RPN #148 indicated family member approached him/her at the start of his/her evening shift and stated he/she had requested resident #026 to be put to bed twice by day staff and resident was not put to bed. RPN stated he/she immediately got PSW#149 and #150 to put resident back to bed and went to assess resident #026's status. The RPN indicated resident #026 had not been provided care as set out in the plan of care.

An interview conducted with PSW #149 indicated RPN #148 asked him/her and PSW #150 to transfer resident #026 to bed immediately. PSW #149 stated it was unusual for resident #026 to not be in bed, when he/she was asked to put resident in bed. PSW #149 stated he/she went to the resident's room with PSW #150, observed resident to be sitting in his/her assistive device. PSW stated once transferred to bed the two PSW's changed resident and resident was lightly incontinent.

An interview with PSW#150 confirmed he/she assisted PSW#149 in transferring and changing resident #026 on the identified date. The PSW indicated the resident had not been provided care as set out in the plan of care.

Interview with Associate Director of Care (ADOC) #106 confirmed the above incident had occurred and home had started an investigation. The ADOC indicated resident #026 was not checked after PSW #146 provided the morning snack and did not provide the care set in the plan of care.

The home is being served an order as resident #042 sustained injury and care set out in the plan of care was not provided to resident #026 and resident #042 as specified in the plan.

The home has ongoing non-compliance with legislation, s. 6 (7) which is as follows:
1) March 7, 2016, Inspection Number 2016_391603_0005, VPC's related to Responsive Behaviours, Fall Prevention, and Personal Support Services.

2) May 18, 2016, Inspection Number 2016_391603_0005, CO related to Responsive Behaviours, Fall Prevention, and Personal Support Services.

3) October 22, 2015, Inspection Number 2015_356618_0018, WN related to Personal Support Services.

4) April 22, 2014, Inspection Number 2014_168202_0011, VPC's related to Responsive Behaviours and Personal Support Services.

5) November 27, 2013, Inspection Number 2013_168202_0063, VPC related to Responsive Behviours.

The severity of the non-compliance and the severity of harm and risk is actual.

The scope of the non-compliance is a pattern. (647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 2017

Order # / Ordre no : 002

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. Duty to protect

Order / Ordre :

Within one week of receiving this order, the home shall provide a plan to the inspector on February 24, 2017, the plan shall include:

1) Identifying when all staff will receive education on abuse and neglect of residents. The education shall include staff recognition of all forms of abuse and neglect defined under the legislation.

2) Education of all staff on the home's Zero Tolerance Of Abuse and Neglect policy.

The plan is to be submitted to shihana.rumzi@ontario.ca within one week of receipt of this order.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the resident was protected from neglect by the licensee or staff in the home.

Neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents. O. Reg. 79/10, s. 5.

a. On an identified date, family member of resident #026 approached Inspector #604 and indicated the following:

On an identified date, the family member arrived to spend the day with resident #026 and the staff got resident #026 up that morning. The family member indicated he/she requested a PSW to change and put the resident in to bed, as the resident was very tired. The family member re-approached the same PSW

and requested he /she assist resident #026 back into bed. The family member indicated he/she then approached the RPN on an identified shift and requested staff assist resident #026 with continence care and transfer the resident into bed for a rest.

The family member stated he/she observed the resident's brief to be soaked, long with the pants and wheel chair seat to be wet with urine. The family member indicated the evening PSW's who's names he/she was unaware, were very apologetic.

An interview with the family member revealed he/she was unable to recall the name of the staff or provide a description of the staff member he/she approached to get resident #026 changed and put to bed after lunch.

The home submitted an identified CIS report on an identified, indicating the following:
Resident #026's primary care staff on the day shift was PSW #146. An interview with PSW #146 confirmed he/she provided care to the resident and got resident up with the assistance of PSW #147. The PSW indicated he/she is aware of resident's plan of care and indicated the resident is to be put to bed during the day. The PSW indicated the last time he/she checked on resident was when he/she brought the resident's morning snack as family was with resident and anticipated family would ask for assistance when needed. The PSW confirmed he/she did not check or provide any care to resident #026 after an identified date, that morning, and did not see the resident prior to the end of his/her shift.

Interview conducted with RPN #108 confirmed he/she worked on an identified date and shift. The RPN indicated resident #026 had family with him/her the whole day and PSW #146 was the resident's primary PSW. The RPN indicated resident #026's plan of care directs staff to put resident back to bed after lunch for a rest and was unaware that resident was not put to bed on the identified day till the next shift when he/she reviewed the shift report on his/her next shift.

Interview with PSW #147 confirmed he/she assisted PSW#146 with resident #026's morning care and transfer on the date indicated and was not asked for further assistance throughout the shift by PSW#146. The PSW further indicated he/she was not approached by family asking to assist with putting resident #026 back to bed.

Interview with RPN #148 indicated family member approached him/her at the start of his/her identified shift and stated he/she had requested resident #026 to be put to bed twice by day staff and resident was not put to bed. RPN stated he/she immediately got PSW#149 and #150 to put resident back to bed and went to assess resident #026's status. The RPN indicated the incident constituted neglect as resident #026 was not put to bed or changed until the evening shift and care was not provided as per plan of care.

An interview conducted with PSW #149 indicated RPN #148 asked him/her and PSW #150 to transfer resident #026 to bed immediately. PSW #149 stated it was unusual for resident #026 to not be in bed. PSW #149 stated he/she went to resident's room with PSW #150, observed resident to be sitting in his/her wheel chair, did not see signs of incontinence.

An interview with PSW#150 confirmed he/she assisted PSW#149 in transferring and changing resident #026 on the identified date. The PSW identified that the incident goes against the Resident's Bill of Rights as the care plan was not followed for resident #026.

Interview with Associate Director of Care (ADOC) #106 confirmed the above incident had occurred and home had started an investigation. The ADOC indicated resident #026 was not checked after PSW #146 provided the morning snack and indicated resident #026's care needs where neglected.

b. The home submitted an identified CIS report on an identified date, to the MOHLTC that indicated alleged misuse or misappropriation of funds involving resident #051.

Record review of the home's investigation notes revealed that a written complaint was submitted to the Director of Care (DOC) by resident #051's Substitute Decision Maker (SDM) for care and finances indicating there were two cheques cashed from the resident's personal bank account by a former PSW #141, on two identified dates in 2016.

Review of the home's CIS and an interview conducted with the DOC revealed as of an identified date, PSW#141 was no longer employed at the home.

Record review of the home's investigation notes revealed a photocopy of two-cashed cheques from resident #051's personal account by PSW #141, on two

identified dates.

An interview conducted with resident #051 indicated that he/she could recall the incident indicated above as a police officer visited the resident regarding the incident. The resident could not recall the specific details of the incident.

An interview with resident #051's SDM for care and finances revealed that he/she identified the two cashed cheques on an identified month, monthly statement of resident #051's personal bank account. A personal cheque was cashed from the resident's personal account to PSW #141 on another identified date.The SDM also reported that there was another cheque cashed a few days prior to the first cheque, for an identified amount of money.

An interview with PSW #141 revealed that he/she stated he/she couldn't recall the incident and denied misuse or misappropriation of resident #051's money.

Interviews with the ADOC and the DOC indicated that the home's investigation determined the cheques were written and signed in the same handwriting as PSW #141's handwriting. The DOC indicated that the home ended their investigation, as the police department initiated an investigation and PSW #141 had resigned before the incident was reported to the home by the POA.

The home is being served an order as the two incidents of abuse inspected had direct impact on the identified residents above.

The home has ongoing non-compliance with legislation, under LTCHA, 2007,. O. Reg 79/10.
s. 19.:

1) March 7, 2016, Inspection Report 2016_391603_0006, CO related to Prevention of Abuse, Neglect and Retaliation.

The severity of the non-compliance and the severity of harm and risk is actual as resident #026 was not provided care as set of out in plan of care and resident #051's money was misused or misappropriation by an identified home staff member.

The scope of the non-compliance is a pattern.
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 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) (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 :

Within one week of receiving this order, the home shall provide a plan to the inspector on February 24, 2017, the plan shall include:

1) How the home will ensure that for each resident demonstrating responsive behaviours strategies be developed and implemented to respond to responsive behaviours.

2) Follow-up methods to ensure recommendations from outside health care providers are reviewed and represented in resident's plan of care.

The plan shall be submitted to shihana.rumzi@ontario.ca. within one week of receipt of this order.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a written record was kept related to the evaluation of the responsive behaviour program that included the following: date of the evaluation and the date of the changes were implemented.

Record review of home's annual evaluation of the responsive behaviour program for 2015, and interview with ADOC#115 revealed that the date of evaluation and the date that the changes were implemented, were not documented in the evaluation.

2. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours, where possible.

The home submitted an identified CIS report on an identified date, indicating there had been an altercation where resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same identified location of the home. Minutes later resident #041 re- approached resident #042 and attempted to remove the garment again causing a tug of war which then resulted in resident #042 sustained an injury needing to be transferred to hospital.

The home subsequently submitted an identified CIS report, indicating that there had been an altercation where resident #041 approached resident #043 in an identified location of the home and struck him/her with an identified object.

A review of resident #041's clinical records revealed that the resident had been identified behaviour on admission and revealed multiple documented incidents of an identified responsive behaviour.

Interviews with RPNs #119 and #134, PSWs #101, #104, #120, and #121 indicated that resident #041 has exhibited identified responsive behaviours toward residents and staff. The staff further indicated that the resident is often unable to understand what is being said to him/her and an identified responsive behaviours will escalate if individuals raise their voices at him/her. RPN #134 revealed that he/she continues to care for the resident, does not feel safe doing so and feels the residents continue to be at risk of harm. PSW #120 revealed that it is difficult to monitor resident #041 at all times and stated that there are no developed strategies and interventions to respond to the above mentioned behaviors.

The above mentioned staff further indicated that both residents and staff had been subject to resident #041's identified responsive behaviours from the time of resident's admission. Staff indicated that it has been difficult to manage resident #041's responsive behaviors and are frustrated with the lack of developed strategies and interventions that would assist in minimizing the responsive behaviors.

Resident #041's written plan of care identified the resident's responsive behaviours, with no further responsive behaviors identified. The progress notes indicated that resident #041 was sent to hospital on specialist assessment on an identified date, two days after the above mentioned incident whereby resident #042 sustained a injuries following an altercation with resident #041. A further review of the written plan of care for resident #041 revealed that there had been only one addition to his/her plan of care following his/her return to the home on an identified date, after the specialist assessment.

A review of the clinical records revealed that the physician ordered a Behavioral Support Service Mobile Support Team (BSO) referral on an identified day. Upon further record review inspector was unable to locate any further correspondence related to the BSO referral.

Interviews with DOC, ADOC #106 and RPN #124 confirmed that a referral to the BSO had been processed, however, at the time of the interview neither staff were aware of the location, recommendations or strategies documented by the BSO team. Within one hour the DOC had retrieved the BSO recommendations.

A review of the Behavior Support Plan on an identified date provided the home with 16 written recommendations to manager resident #041's responsive behaviours. A summary of the recommendations.

An interview with the ADOC confirmed that the strategies provided by the BSO on an identified date, had not been assessed nor developed and utilized in resident #041's plan of care.

An interview with the DOC indicated that residents' identified with responsive behaviors are discussed at the monthly Resident Safety and Risk Management Committee meetings. The DOC further indicated that the meetings are intended to develop and implement strategies with the direct care staff on how to manage the aggressive behaviors of residents that pose a risk to co-residents and staff.

The meeting minutes reviewed for a two month period, from the Resident Safety and Risk Management Committee Minutes revealed that resident #041 had been mentioned in four months of minutes and the plan was to conduct monthly meetings and track incidents. On an identified month, the meeting minutes identified resident #041 as being unwell and to revisit his/her care the following

meeting.

Interviews with the DOC and the ADOC indicated that resident #041 had been identified with responsive behaviors that had been exhibited toward residents and staff. Both the DOC and the ADOC further confirmed that there had not been any strategies developed or implemented to respond to resident #041's responsive behaviors, as the 16 recommendations from the BSO team was not communicated by the home to the direct care staff who provided care to resident #041.

The home is being served an order as the inspectors inspected two incidents of responsive behaviours for resident #041 with direct impact to the residents in the home.

The home does not have any previous non-compliance with r. 53. (4).

The severity of the non-compliance and the severity of harm and risk is actual as resident sustained an identified injury.

The scope of the non-compliance is isolated.
(647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

Within one week of receiving this order , the home shall provide a plan to the inspector on February 24, 2017, the plan shall include:

1) How the home will ensure that the set plan of care will be provided for the residents.

2) Ways the home will ensure residents presenting with responsive behaviours will be assessed, procedures and interventions that will be developed to assess the risk of harm to residents in the home.

The plan shall be submitted to shihana.rumzi@ontario.ca. within one week of receipt of this order.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behavior, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The home submitted an identified CIS report on an identified date, indicating there had been an altercation where resident #041 approached resident #042 in an identified location of the home and attempted to remove a garment from #042. Staff intervened at this time by separating the two residents however left the two residents in the same identified location of the home. Minutes later resident #041 re- approached resident #042 and attempted to remove the garment again causing a tug of war which then resulted in resident #042 sustained an injury needing to be transferred to hospital.

The home subsequently submitted an identified CIS report indicating that there had been an altercation where resident #041 approached resident #043 in an identified location of the home and struck him/her with an identified object.

A review of the census record for resident #041 revealed that he/she had been admitted to the home on an identified date to an identified home area, then relocated to another home area shortly after, then once again relocated to another home area shortly after the last relocation. The plan of care for resident #041 identified the resident to have responsive behaviors which have been exhibited towards staff.

A clinical review of the progress notes for an identified period of time, revealed multiple documented incidents where residents and staff had been at risk of harm or had been harmed during interactions with resident # 041.

A review of the progress notes for 13 months, revealed 15 incidents involving resident #041.

Interviews conducted with RPN's #119 and #134, PSW's #101, #104, #120, and #121 indicated that resident #041 has exhibited identified responsive behaviours towards residents and staff, with identified targets and will escalate. The staff further indicated that the resident is often unable to understand what is being said to him/her and the identified responsive behaviours will increase if individuals raise their voices at him/her. RPN #134 revealed that he/she continues to care for the resident, does not feel safe doing so and feels the residents on the unit continue to be at risk of harm. PSW #120 revealed that it is difficult to monitor resident #041 at all times and stated that other staff and residents are at risk of being harmed due to his/her unpredictable responsive behaviors.

The above mentioned staff further indicated that both residents and staff had been subject to resident #041's identified responsive behaviours from the time of resident's admission. Staff indicated that it has been difficult to manage resident #041's identified responsive behvaiours behaviors and are frustrated with the lack of developed strategies and interventions that would assist in minimizing potential altercations that have the ability to harm residents and staff.

A review of the clinical records revealed that the physician ordered a BSO referral on an identified date. Upon further record review the inspector was unable to locate any further correspondence related to the BSO referral which would have included an assessment and or recommendations.

Interviews with the DOC, ADOC #106 and RPN #124 confirmed a referral to the BSO had been processed on an identified date, however, at the time of the interview neither staff were aware of the location, recommendations or strategies documented by the BSO team. Within one hour, the DOC had retrieved the BSO recommendations.

A review of the Behavior Support Plan, provided the home with sixteen written recommendations that would assist staff in responding to resident #041's responsive behaviors.

An interview with ADOC #141 confirmed the mentioned strategies provided by the BSO on an identified date, had not been assessed nor developed and utilized in resident #041's plan of care.

An interview with the DOC indicated that resident's identified with responsive behaviors are discussed at the monthly Resident Safety and Risk Management Committee (RSRM) meetings. The DOC further indicated that the meetings are intended to develop and implement strategies with the direct care staff on how to manage the identified responsive behaviors of residents that potentially put co-residents and staff at risk.

The meeting minutes reviewed for an identified period of time from the RSRM minutes revealed that resident #041 had been mentioned on four of the meeting minutes and the plan was to conduct monthly meetings and track incidents. The meeting minutes for an identified month identified resident #041 as being unwell and to revisit his/her care the following meeting.

The DOC confirmed that resident #041 had not been discussed at any of the RSRM meetings and should have been as he/she posed a risk to others. The DOC further confirmed that procedures and interventions have not been developed or implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #041's responsive behaviors.

The home is being served an order as the licensee had not developed or implemented procedures and interventions to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

The home has ongoing non-compliance with r. 55. (a), which is as follows:

1) November 27, 2013, Inspection number 2013_168202_0063, CO related to Responsive Behaviours

The severity of the non-compliance and the severity of harm and risk was actual harm. The scope of the non-compliance is isolated.
(647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 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 16th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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