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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 17, 2017 | 2016_324535_0006 | 027286-16 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

Downsview Long Term Care Centre Limited
3595 Keele Street NORTH YORK ON M3J 1M7

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

Downsview Long Term Care Centre
3595 Keele Street NORTH YORK ON M3J 1M7

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

VERON ASH (535), ADAM DICKEY (643), SLAVICA VUCKO (210)

## 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): September 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, and October 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 2016.**

**The following critical incident (CI) inspections were conducted concurrently with the RQI: 009035-14 (related to abuse), 001495-14 (related to abuse), 019039-16 (related to abuse), 019081-15 (related to falls and reporting incidents), 025025-15 (related to falls), 023823-16 (related to falls and reporting incidents), 023889-16**

**(related to falls), 026483-16 (related to responsive behavior, resident's bill of rights and reporting incidents), 026756-16 (related to safe and secure home, plan of care and reporting of incidents), 028187-16 (related to abuse), 028622-16 (related to abuse), 028624-16 (related to abuse), 030387-16 (related to responsive behavior and abuse).**

**The following complaints were conducted concurrently with the RQI: 001863-15 (related to responsive behavior and abuse), 004566-16 (related to responsive behavior, laundry services and resident's bill of rights), 028104-15 (related to housekeeping and pest control), 034873-15 (related to safe and secure home), 007353-16 (related to plan of care, communication system, and emergency plans), 029153-15 (related to nursing and personal support services, medication administration and dietary services).**

**During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant DOC (ADOC), clinical coordinator, Resident Assessment Instrument (RAI) coordinator, staff educator, registered dietitian, physiotherapist (PT), director of programs, environmental service manager, (ESM), food service manager (FSM), food service supervisor (FSS), social worker, registered nursing staff, personal support workers (PSWs), dietary aide, housekeeping staff, hairstylist, receptionist, residents, substitute decision makers (SDMs), Residents' Council president and Family Council president.**

**During the course of the inspection, the inspectors(s): conducted a tour of the home; observed meal services, medication administration, staff to resident interactions and the provision of care, resident to resident interactions; and reviewed resident health care records, staff training records, meeting minutes for continuous quality program, registered staff, Residents' Council and Family Council, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Food Quality**
**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**
**Quality Improvement**
**Recreation and Social Activities**
**Reporting and Complaints**
**Resident Charges**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**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 failed to fully respect and promote multiple residents' right to have personal health information (within the meaning of the Personal Health Information Protected Act, 2004) kept confidential.

A review of intake log #026483-16 on an identified date revealed that a personal health information package related to a resident was submitted to Minister Hoskins and parties at the Ontario Long Term Care Association (OLTCA) for review and response to a situation that was considered an urgent matter to the home.

On an identified date the home's Director of Care (DOC) #106 created a package which contained a compilation of a variety of medical and non-medical documents and forwarded the information to both the Minister and the OLTCA office. The package contained an introductory letter addressed to the Minister outlining their concerns regarding a resident in the home and that despite concerted efforts to address the concerns and behavioral issues with external support they have been unable to resolve them. Therefore, the letter was a request to refer the resident to an appropriate environment suitable to manage his/her behaviors and provide personal care.

During an interview with the DOC, he/she acknowledged sending the package to the Minister and the OLTCA. He/she also stated that they were urged by to find suitable placement for the resident; and that as a result of that request, they gathered all related documents, created a summary of incidents and events, and included all external resource information and hospital consultations to develop the package which was sent to the Minister. Furthermore, the DOC stated that they sent the package to the OLTCA because the organization was an advocate for the home. When asked directly if the resident's substitute decision maker (SDM) gave consent to send the package containing the resident personal health information to the Minister and the OLTCA, the DOC stated that the SDM did not specifically consent to send the package. However the DOC admitted that the package contained personal health information, and that there were concerns related to privacy and confidentiality especially because of the package sent to the OLTCA. When asked directly if he/she did anything to mitigate the consequences of disclosing the resident personal health information, the DOC stated that they did not believe it was a breach of confidentiality to send the OLTCA information so that they could review the resources available to the home.

During an interview with resident's SDM, he/she stated that they were not aware of a package containing personal health information was sent to the Minister or to the OLTCA. The SDM stated that permission was granted only to send the resident and personal information to another facility for assessment and treatment so that he/she could be returned to the home.

On an identified date the inspector contacted the OLTCA and confirmed that they received the package sent by the DOC of the home, but that they immediately shredded the entire package except for the letter, which was kept because it was a letter from a member of the association.

On an identified date the home's Administrator was interviewed and he/she stated that the package was sent by DOC to the Minister and the OLTCA. The Administrator also stated that the person from the LHIN told them that the package also went to HRH, and he/she requested a teleconference call with the team to discuss the breach of privacy. On an identified date the Administrator also wrote a summary which stated that the breach of privacy would be considered a non-compliance incident that would need to be declared on the Compliance Declaration and requested an action plan related to the prevention of further privacy breach by the home in the future.

On an identified date, in his/her response to the email from the LHIN, the Administrator quoted paragraph 40 (1) under 'Disclosures related to risks' as a way of explaining the reason for the home sending the package in question to the Ministry of Health. The Administrator further apologized for any wrong doing related to the interpretation of the Act. He/she also stated that having sent the same package to OLTCA was wrong and the person responsible for the email has been spoken to; and as well, that he/she contacted the OLTCA and was assured that the package was destroyed. The Administrator informed the inspector that he/she wrote in an email to the LHIN to assure them that another breach would not occur in the future and that he/she would ascertain that all Management Staff closely working with personal health information would review the Personal Health and Protection Act and complete the annual Mandatory 3-part education segment on the electronic education program.

The scope of the non-compliance is patterned. The severity of the non-compliance is minimal harm/risk or potential for actual harm/risk. A review of the compliance history revealed a previous non-compliance (unrelated) was issued under inspection report # 2015_321501_0021 on October 29, 2014.

***Additional Required Actions:***

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

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Review of a Spills Action Centre (SAC) report for submitted to the Ministry of Health and

Long-Term Care (MOHLTC), revealed resident #046 was in his/her room resting in bed when an altercation occurred with resident #045 which cause injury requiring treatment. The report stated resident #045 was likely confused and believed that this was his/her room which led to the altercation with resident #046 who was resting in his/her bed.

Interview with Recreation Assistant (RA) #169 revealed that on an identified date, at an identified time he/she was conducting a resident activity when a noise was heard from a nearby room. RA #169 stated he/she observed resident #046 coming out of the his/her room with an injury requiring assessment and treatment. RA #169 stated that there was an altercation between resident #046 and resident #045. RA #169 stated resident #045 was attempting to get in resident #046's bed, but that he/she escorted resident #045 back to his/her own room.

The progress note showed that according to resident #046 he/she was sleeping and resident #045 entered the room. Resident #046 told resident #045 to leave the room, which sparked the altercation between the two residents.

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Review of a progress note entered by registered staff RPN #117 on an identified date approximately three weeks prior to the incident, revealed that resident #045 had been observed with responsive behavior towards a co-resident with the mobility device. Staff removed resident #045 from the area.

Interview with RPN #117 revealed he/she was unsure if resident #045 was serious when he/she was displaying responsive behavior towards co-resident as resident #045 liked to joke around. RPN #117 indicated that this was a new behavior for resident #045. RPN #117 stated that additional monitoring of resident #045's behavior was not initiated as a result of this new behavior.

Interview with RN #174 revealed that staff members on the unit were aware that resident #045 had exhibited identified responsive behaviors. RN #174 stated that resident #045 was able to ambulate without the assistance of the mobility device. RN #174 was unaware of the incident of responsive behavior on the previously mentioned identified date.

Interview with the DOC revealed that he/she had not been made aware of resident #045's responsive behavior. DOC further stated that resident #045 should have had his /her behavior monitored and assessed by registered staff since that was a new responsive behavior. The DOC confirmed that in this case the licensee had failed to

ensure that resident #046 was protected from abuse by anyone.

2. Critical Incident Report was submitted to the MOH on an identified date. The report noted that on an identified date there was an altercation between resident #023 and resident #024 in resident #023's room. Resident #024 had a fall which caused an injury requiring transfer to hospital, and a procedure was performed related to the injury. Record review showed that resident #024 has an identified responsive behavior; and he/she was sometimes found in other residents' rooms and/or sleeping in other residents' beds.

Record review and interviews with both staff confirmed that on an identified date, registered staff RN #150 was alerted by PSW #161 to visit resident #023's room immediately where the incident occurred.

During an interview, registered staff #150 stated that this was an incident of abuse committed by resident #023 during the altercation in his/her room. During an interview, the home's DOC #106 acknowledged the incident as an act of abuse towards resident #024.

3. While conducting record review related to a critical incident which involved resident #023, the inspector read a progress note which lead to the inspection of this incident. The progress notes revealed that resident #030 was assessed as moderate cognitively impaired; and has an identified behavior. He/she was provided behavioral support through psychotropic medications and external resources. Resident #023 was mildly impaired and independently ambulated with a mobility device. Resident #023 also had an identified responsive behavior. Over an identified period of months, the progress notes revealed that resident #023 exhibited inappropriate responsive behaviors towards resident #030.

On an identified date, Physician #179 recommended that resident #023 be prescribed a medication to treat his/her inappropriate responsive behaviors. Although the identified responsive behavior had decreased, on another identified date after the treatment started, resident #023 had another inappropriate behavior towards resident #030.

Interviews with PSW #175 and registered staff #156, 162, and 150 confirmed that all documented incidents stated in the progress notes actually occurred. Both registered

staff also confirmed that resident #023 directed inappropriate responsive behaviors towards resident #030 which constituted abuse. During an interview with DOC #106 and Clinical Coordinator #133, both acknowledged that they were aware of these incidents of inappropriate behavior towards resident #030. The home did not complete an assessment for either resident's ability to consent to these behaviors.

The home's DOC #106 stated during an interview that the behaviors were documented; and it depends on the level of risk and the risk that was afflicted in terms of reporting of such incidents to family or the Ministry of Health.

4. While conducting a record review related to another critical incident which involved resident #023, the inspector read a progress note which lead to the inspection of this incident. Record review revealed that resident #031 was cognitively impaired and non-communicable; and resident #023 was mildly impaired and independently ambulated with a mobility device. The progress notes showed that resident #023 had identified inappropriate responsive behaviors; and that on an identified date, resident #023 engaged in an inappropriate behavior towards resident #031.

During an interview with registered staff #150, he/she confirmed that the incident occurred as was documented with no harm noted to resident #031. The staff confirmed that management was made aware of the incident but that the police and family were not notified. During an interview with DOC #106 and Clinical Coordinator #133, both acknowledged that they were aware of the incidence; and the DOC confirmed that the incident was documented in the progress notes by the registered staff however the resident was not harmed and therefore the incident was not reported to the family or the MOHLTC.

5. A SAC report was submitted on an identified date to the MOH which revealed that there was ongoing altercation between resident #027 and resident #028. It noted that resident #028 was going outside through a door pass resident #027 when he/she engaged resident #028 in an altercation while uttering inappropriate words.

A review of both residents' progress notes revealed that they both had identified responsive behaviors; and that they were permitted to go outside independently. A review of the progress notes also revealed that on an identified date, resident #028 refused to hold a door open for resident #027 and that sparked the beginning of a series

of altercations between the two residents. According to the records, on an identified date, resident #028 asked resident #027 to return borrowed items and resident #027 refused. At a later time during the shift, resident #027 engaged in inappropriate responsive behavior and gestured towards resident #028 while uttering inappropriate words.

During separate interviews with registered staff #131 and #146, both confirmed that the incident occurred as documented. Registered staff #146 further stated that both residents were immediately separated to prevent further altercations, and that resident #027 was informed that his/her behavior was unacceptable. Both residents' progress notes revealed that additional altercations occurred between the two residents without injury.

On an identified date, the progress notes showed that resident #028 expressed feelings of unpleasantness when around resident #027 following the incident; and on another identified date, while resident #028 was exiting the door on the way outside, resident #027 engaged with him/her in an altercation and again uttered inappropriate words.

During an interview with the DOC, he/she stated that resident #028 came to the office to report the altercations with resident #027 and at that time, the police were notified and attended the home.

During an interview with resident #027, he/she stated that the words and gestures were supposed to be a joke and was not to be taken seriously. He/she stated that they just wanted to scare resident #028.

During the interview, registered staff #146 stated that the altercation between the two residents constituted abuse of resident #028. During the interview, the Director of Care #106 confirmed the incident was abuse of resident #028 by resident #027.

6. The Toronto Service Area Office (TSAO) of the Ministry of Health and Long Term Care (MOHLTC) initiated an inspection on an identified date to inspect a related complaint sent by the home to the Minister. The complaint alleged multiple incidents of inappropriate responsive behaviors by resident #027 toward other residents and staff in the home.

Record review of the minimal data set (MDS) assessment tool revealed that resident #027 had impaired cognitive skills, poor decision making, and required supervision for

care and treatments. He/she could independently ambulate with a mobility device and was able to go outside independently; and the progress notes showed that he/she had an identified behavior.

A review of the progress notes revealed that since an identified date, the resident was admitted to hospital multiple times related to his/her diagnosis. Following the longest period of hospital admission over a period of identified months, the resident was transferred back to the home without the ability to ambulate independently.

A review of the assessment records showed that an external resource team was consulted to help support the resident's responsive behaviors. The assessment records also revealed that the resident was displaying these behaviors towards staff and other residents in the home. The assessment record also showed that on an identified date, the resident's displayed responsive behaviors which the home did not support as recommended by the external resource team and the resident's family. On an identified date, the external resource team assessed the resident and recommended changes and adjustments to the resident's medications. The physician lead #180 also recommended that the home created a schedule to support the identified behavior.

On an identified date, the external resource team consultation notes read that the resident had some improvement in behavior but that he/she was displayed responsive behaviors to express a need. The external team again recommended that the home was to meet with the family and develop a plan related to the resident's identified behavior, and also create a plan to ensure the safety of other residents in the home.

On an identified date, the external term notes revealed that the resident repeatedly requested to go outside. During an interview with the resident's SDM #141, he/she stated that they were unable to support the cost of a private caregiver; and therefore requested help from the home to implement and support this intervention. During an interview with the external resource nurse #155, he/she stated that some of the team's recommendations were adapted by the home, however there were some recommendations that the external team felt could have really helped the case, but they were not followed up or implemented by the home. One such recommendation was the acknowledgement of the resident's responsive behavioral trigger. The external resource nurse also stated that during subsequent visits, he/she reviewed the progress notes and noted that the resident was being prevented from going outside which triggered continued inappropriate responsive behaviors.

During an interview, registered staff #146 confirmed that the home's Director of Care #106 did not want the resident to go outside because of the safety risk given the resident's recent diagnosis; therefore the resident's care plan listed an associated intervention to discourage the resident from going outside at the time. The registered staff also confirmed that the home provided one to one personal care support for the resident; however that intervention was provided inconsistently and for short durations during for approximately three shifts.

During an interview with the home's Director of Care #106, he/she confirmed that they did not want the resident to go outside because of safety reasons. The DOC also confirm that the home did not discuss or create a written contract with the resident or the resident's SDM related to the resident's identified behavior; nor did they address the issue of safety for other residents in the home as recommended by the external resource team.

7. On an identified date, the home reported an incident of resident to resident abuse to the Ministry. According to the incident report, at an identified time during the shift, resident #035 was witnessed in his/her room by a staff member engaging in an altercation with resident #014. Resident #014 had wandered into resident #035's room; and according to resident #014's care plan, he/she needed redirection and supervision. The police was called, and resident #014 was transferred to hospital for assessment and treatment.

Interview with resident #035 revealed that he/she reported to the home about other residents entering his/her personal space; and indicated that the response from staff was ineffective in preventing this from occurring.

Interview with PSW #123 revealed that a few months ago, he/she saw resident #035 in his/her room waving the mobility device in the presence of another resident who attempted to enter the private space. During an interview, registered staff RN #104 revealed that the resident usually activate the call bell for staff to come and remove other residents from his/her room, however in this instance the resident did not call to have the resident removed.

The scope of the non-compliance is patterned. The severity of the non-compliance is actual harm/risk. A review of the compliance history revealed an ongoing non-compliance

with a VPC or CO. A CO was issued under inspection report # 2014_321501_0021 on October 29, 2014. [s. 19. (1)] (210)

***Additional Required Actions:***

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

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**WN #3: 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).**

**s. 8. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the skin and wound, complaint, restraint, and personal care policies were put in place and implemented in accordance with all applicable requirements under the Act.

Registered staff #126, #150, #131, and #114 stated during interviews that they did not have access to policies applicable to skin and wound, complaint, restraint, and personal care policies on their units. During an interview with the home's DOC and ADOC both acknowledged that they had been in the process of developing the nursing program policies for the past year and a half; and confirmed that the policies were not put in place and implemented for direct care providers working in the home.

2. The licensee failed to ensure that the responsive behavior policy was put in place and implemented in accordance with all applicable requirements under the Act.

During interviews, registered staff #131, #146, #114, #126, #127, and #150 stated that they have not seen a responsive behavior policy in the home. During an interview with the home's DOC and ADOC both acknowledged that they have been in the process of developing the nursing program policies for the past year and a half; and confirmed that the policies have not been made available to staff on the units.

3. The licensee has failed to ensure that medication administration policy was complied with.

Reviewed Complaint Log #029153-15 submitted to the MOHLTC on an identified date. The complainant stated that resident #037 was administered medication that was not warranted and not signed for.

On an identified date resident #037 was administered medication as required. During an interview registered staff #145 stated that he/she administered the medication to the resident, but did not sign the medication administration record (MAR) immediately after administering the medication to the resident. Subsequently, the staff had forgotten to sign the MAR that evening and left the facility at the end of the shift. After the interview, the registered staff was alerted to the omission of the signature and returned to the resident's MAR to sign on the applicable date and time. The home's Pharmacy vendor implemented the Administration of Medication Policy # 7.2 As Needed (RPN) Medications, revised on an identified date. A review of this policy revealed that registered staff was to document medications administered on the MAR for the corresponding date and time immediately for each medication administration. During an interview with the clinical coordinator, he/she confirmed that the registered staff did not comply with the listed pharmacy policy during the dated medication pass.

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

A Critical Incident Report (CIR) was submitted to Ministry of Health and Long Term Care (MOHLTC) on an identified date, related to resident to resident abuse. According to the incident report, at an identified time, resident #035 was witnessed in his/her room by a staff member with a mobility device in his/her hand striking resident #014 who had

wandered into resident #035's room.

A review of the policy "Responsive Behaviors" dated April 2016, revealed a procedure for dealing with resident responsive behavior events. As part of the investigation, examine the following: resident's history and plan of care, environmental factors (noise, heat, cold), physiological factors (pain, constipation, infection, change in blood sugar level, hunger/thirst, non-compliance with medication), social factors (loneliness, dispute with another person, recent life-altering event, fear, frustration), caregiver approach (whether person-centered, respectful, any change in routine), resident rights (privacy, personal space, basic needs met), implement referral and review any recommendations from the psych-ogeriatric team, psychiatrist, mental health worker.

A review of resident #035's progress notes revealed two incidents of physical aggressive behavior of resident #035 towards other residents.

On an identified date and time resident #035 had an altercation with resident #015. Resident tried to strike resident #015 with his/her mobility device while passing by. Both residents were separated by staff to avoid further altercation.

On an identified date and time, resident #035 was threatening another resident with unkind words while making threatening gestures. The other resident told staff that resident #035 was making gestures towards him/her. Registered staff #139 escorted resident #035 back to his/her unit. A CIR was submitted to MOHLTC on an identified date and the police were called.

A review of the clinical record indicated that the resident was assessed by GMOT team on an identified date related to aggressive behavior but there was no mention about the threat that was made towards the other resident with the mobility device.

Interview with PSW staff #123 revealed in the last few months the resident did not want anyone on his/her bed or in his/her private personal space, and he/she had seen the resident showing the mobility device to other residents who wandered and were trying to enter his/her room. The staff indicated that the resident did not want residents who wandered with him/her in the elevator or nearby in the hallway. Staff would remove residents who wandered from his/her room and/or from the elevator when resident #035 was in the elevator. Interview with staff #120 revealed that resident #035 was annoyed by other residents entering into his/her room or his/her personal space.

Interview with registered nurse staff #104 indicated that the resident should have been referred to GMOT team after the incidents on the identified date for further assessment of his/her behaviors and confirmed that he/she was not referred.

5. The licensee failed to ensure that the record was kept in a readable and useable format that allows a complete copy of the record to be readily produced.

Interviews with registered staff on the units confirmed that a copy of the home's policies were not available on the units for staff to implement in practice on everyday basis. Throughout the inspection, staff were not able to produce copies of policies requested as the home did not make them available to staff on the units in a readable and usable format.

The scope of the non-compliance is patterned. The severity of the non-compliance is minimum harm/risk or potential for actual harm/risk. A review of the compliance history revealed no previous noncompliance.

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that for each resident height is measured and recorded annually.

Record review of residents from the Resident Quality Inspection stage one census sample revealed that 33/40 residents in the sample did not have height measured and recorded in the last year. 22/40 of the sample residents did not have a height measured or recorded in a three year period.

Interview with Registered Dietitian (RD) #105 revealed that he/she had been aware that resident heights were not being measured and recorded annually, and that he/she was more concerned with getting resident weights completed. RD #105 confirmed that heights were not measured and recorded annually, and that the expectation of the home is for heights to be measured and recorded on admission and annually thereafter.

Interview with the ADOC confirmed that the expectation of the home is to measure and record the height of each resident annually. He/ she confirmed that the licensee has failed to ensure that the height for each resident was measured and recorded annually.

The scope of the non-compliance is widespread. The severity of the non-compliance is minimum risk.
A review of the compliance history revealed a previous Voluntary Plan of Correction (VPC) was issued under inspection report # 2015_398605_0019 on December 3, 2015.

***Additional Required Actions:***

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

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

**2007, c. 8, s. 6 (1).**

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

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

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**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).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,**
**(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**
**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered**

**in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident.

During the staff interview in Stage one RQI inspection, skin and wound care for resident #005 was triggered.

A review of resident #005's treatment administration record (TAR) for the an identified month revealed a daily treatment of a skin impairment with an identified dressing, and to alternate the wound dressing at identified times. A review of the initial physician's order revealed the dressing to the identified area daily.

Interview with registered nurse staff #104 and #139 revealed that resident #005 had a healed impaired skin integrity that was monitored weekly and a treatment was applied daily since an identified date. The nursing staff applied a specific treatment to the skin alteration daily and the identified site was left open without the dressing applied. When asked if the physician's order was clear for the skin impairment to be left open or covered with dressing, registered nurse staff #139 replied that the order was not clear and that he/she contacted the physician to clarify the order. The clarified order indicated the skin impairment was to be treated with an identified dressing and to keep the affected area covered.

A review of the physician's order, the treatment administration record and interviews with registered nursing staff #104 and #139 confirmed that the physician's ordered for a specific dressing to the skin impairment for resident #005's skin alteration treatment was not clear whether the area had to be covered or not.

2. During an interview with resident #011 it was reported that he/she was not being assisted to maintain effective oral hygiene.

Record review of resident #011's written plan of care revealed he/she had oral care needs which required extensive assistance for hygiene and grooming. The written care plan directed staff to instruct the resident in proper handling of denture, and did not provide any direction to staff for caring for resident #011's remaining natural teeth.

Interview with PSW #140 revealed that resident #011's dentures would be cleaned and soaked overnight by night PSW staff. PSW #140 further stated that staff used an oral rinse for oral hygiene, and that resident #011 was not provided assistance with brushing his/her natural teeth.

Interview with RN #126 revealed that oral care should be provided twice daily, or when needed including brushing of resident #011's natural teeth. RN#126 stated that the written plan of care for resident #011 was lacking clear direction for staff who provide care for him/her.

Interview with Clinical Coordinator #133 revealed that resident #011's written plan of care should contain direction for staff to provide care for the resident's dentures as well as natural teeth. Clinical Coordinator #133 confirmed that in this case the licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

3. During stage one of the Resident Quality Inspection (RQI), resident #008 triggered for personal support services from a family interview. According to the SDM, it was believed that the resident's natural teeth was not being brushed daily because the tooth paste provided by family was not being used by the staff.

Record review revealed that resident #008 care plan on an identified date showed that he/she wore dentures; however the resident had some natural teeth. During an interview with the primary PSW #128, he/she stated that the resident's partials and natural teeth were cleaned daily at morning care with the use of the home supplied toiletries. Both primary caregivers - PSW #128 and registered staff #131 were aware that the resident wore upper and lower partials and had some natural teeth; and they both agreed that the care plan was not updated.

During an interview with the clinical coordinator #133, he/she stated if the care plan showed that the resident has dentures, the direct care staff could misunderstand and not brush the resident's natural teeth. He/she also stated that the resident's care plan should list information related to the resident's actual oral assessment status in order to provide clear directions to staff.

4. A Critical Incident (CI) with Log #019039-16 was submitted to the MOHLTC on an identified date related to an incident that caused an injury to a resident for which the resident was taken to a hospital and which resulted in a significant change in the resident

health status. According to the CI resident #023 caused resident #024 to fall onto the floor in his/her bedroom causing resident #024 to sustain an injury which required transferred to hospital, and subsequently, a procedure.

On an identified date resident #024 sustained an injury causing a change in status. The resident's written plan of care was updated however, the plan listed conflicting information since the original information was not removed.

After reviewing the care plan with the inspector, registered staff #156 confirmed that the resident's care plan does not provide clear directions to direct care staff.

5. While reviewing the records of resident #023 progress notes and written plan of care, both showed that there were two identified responsive behaviors which were not included in the resident's responsive behavior plan of care.

Registered staff #156 and 150 confirmed that the information related to these identified responsive behaviors should have been included in the resident's care plan to provide clear direction to all staff on how to manage these behaviors.

6. A review of an identified SAC report was completed related to an incident which occurred in the home on an identified date where resident #027 and resident #028's had an altercation with threatening words uttered by resident #027.

Record review showed that on an identified date, resident #027 was offered tray service by the staff as directed by the home's Director of Care and Administrator because of the altercation which occurred on an identified date with resident #028. Record review also revealed, and interviews with registered staff #130 and #146 confirmed that on identified dates, the resident was served meals in the dining room by staff despite the fact that he/she was to receive tray service sometimes to prevent triggering a responsive behavior.

Record review also revealed that the resident's care plan was not updated with the changes since the care plan still listed meals to be served in the dining room and not tray service. Registered staff #146 also confirmed that the plan of care was not updated and therefore did not provide clear direction for all staff.

During an interview with the DOC, he/she stated that the expectation was that staff followed directions by providing tray service to the resident, and that the care plan should

have been updated to reflect the same and provide clear directions to all staff.

7. A complaint was received by the MOHLTC. A review of resident #013's written plan of care revealed the resident was at moderate risk for falls. Interventions to minimize the number of falls were to check the resident every one hour to ensure safety, call bell to be within reach when in bed and room, and the bed was to be in lowest level after care had been provided.

A review of resident #013's progress notes revealed that communication occurred on an identified date between the registered staff and a family member related to family's concern about a floor mat beside the resident's bed. The staff explained to the family member that the floor mat had been in place.

Interview with the ADOC revealed that a floor mat was used as part of the falls prevention program to prevent injury if a resident was at risk for falls when they were in bed. He/she further stated that because the health status of resident #013 changed, he/she was not able to ambulate after returning from hospital on an identified date, and that the floor mat was placed to prevent injuries in case of falls, however the written plan of care was not updated in order to provide clear directions to staff.

8. On an identified date a critical incident was submitted to MOHLTC that resident #035 had an altercation with resident #014 using a mobility device because resident #014 wandered into resident #035's room at a specific time and fidgeted with resident #035's personal item.

According to resident #014's plan of care, he/she needed to be redirected and supervised. A review of resident #015's responsive behavior written plan of care revealed that staff should be cognizant of not invading the resident's personal space. Interview with the resident revealed that he/she did not want wandering residents in his/her private space or touching his/her private belongings and that staff should do something to prevent that from occurring.

Interview with PSW #138 revealed the resident did not want other residents to come around his/her bed and that the resident usually removed wandering residents from the room. The PSW also stated that he/she noticed that sometimes the resident would show wandering residents the mobility device.

Interview with registered staff #104 revealed when there was a wandering resident in

resident #035's room, the resident would activate the call bell or he/she would come to the nursing station to tell staff to remove the resident from his/her room; and that those methods were working well over the past several months.

A review of the written plan of care and interview with staff #104 confirmed resident #035's plan of care did not provide clear directions to staff.

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

During the stage one of the RQI, resident #008 triggered for choice lacking from a family interview. According to the SDM, he/she has a problem with the fact that staff did not remove the residents facial hair while providing care.

Resident #008 was observed by the inspector to have a moderate amount of facial hair on a few identified dates. During an interview with the resident's primary care PSWs #128 and #111, both stated that they were not aware of the resident's facial hair and therefore did not remove the hair or provide alternative means of removing the facial hair. During an interview, the clinical coordinator #133 stated the expectation was that facial hair was to be removed by staff while grooming and providing personal care if that was the resident's or substitute decision maker's wishes.

10. The Toronto Service Area Office (TSAO) of the Ministry of Health and Long Term Care (MOHLTC) initiated an inspection with Log # 026483-16 on an identified date related to the home's complaint letter to the Minister stating multiple incidents of aggressive responsive behavior by resident #027.

Record review revealed resident #027 had a behavior in which he/she independently engaged in outdoors since he/she was admitted to the home.

Since readmission to the home after an extended stay in hospital, the resident was not able to ambulate independently, and therefore required a wheelchair to go outside. A review of the resident's care plan indicated that he/she was not safe to go outside to engage in this activity; and there was an intervention listed to discourage the resident from going outside for this activity.

During an interview with the resident's substitute decision maker (SDM), he/she stated that the resident should be allowed to go outside to engage in the activity. An interview

with PSW #130 and registered staff #146 confirmed that the home's Director of Care (DOC) had informed the staff to discourage the resident from going outside because if he/she was not able to ambulate independently, it would mean that the home would no longer be able to support the resident living at the home.

According to registered staff #146, the intervention did not support the resident's needs and preferences to go outside to engage in the activity; and therefore caused the resident increased anxiety and a display of altercations sometimes towards other residents and staff in the home.

11. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A complaint was received by MOHLTC that a co-resident was seen engaging in an identified behavior in their room on an identified date.

A review of resident #017's written plan of care created on an identified date revealed the resident was known to engage in this behavior which was not in compliance with the facility's policy.

An interview with registered staff #114 revealed resident #017 was transferred from one room to another on an identified date. Registered staff #114 on the newly located unit was not aware the resident had a history of engaging in this behavior.

An interview with staff #148 revealed on an identified date, he/she had detected an odor in the resident's washroom, but did not report the odor to anyone.

An interview with registered staff RPN #114 revealed if he/she was informed about the resident previous history, he/she would have notified environmental services (ESM) department to install a detector in the washroom.

An interview with EMS revealed he/she did not know resident #017 engaged in the identified behavior, and that if he/she was informed a detector would have been installed in the resident's washroom for safety.

12. Record review of progress notes for resident #005 revealed he/she had been transferred to hospital on an identified date with an alteration in skin integrity. Progress

notes indicate resident #005 remained in hospital until being transferred back to the home on an identified date with an acute diagnosis.

Review of medical diagnoses for resident #005 revealed he/she had multiple diagnosis; and that the physician orders indicated resident #005 received an identified medication daily by mouth.

Review of Final Summary Report with an identified date revealed resident #005 presented with a respiratory symptom. Lab reports indicated he/she had altered blood work results. Resident #005 was provided treatment. Review of discharge instructions dated on an identified date suggested blood work to assess medication levels in one week.

Interview with RN #104 stated the expectation of the home when a resident returns from hospital would be to transcribe discharge orders and communicate with the home physician to ensure assessments were collaborated. RN #104 confirmed the physician at the home was not advised of the discharge instructions from the hospital regarding medication monitoring. RN #104 further indicated the specific medication could be potentially toxic and resident #005 was at risk related to the corresponding diagnoses associated with this medication.

Interview with Clinical Coordinator (CC) #133 revealed the home's expectation was for nursing staff to coordinate and reconcile discharge orders with the home's physician upon return from hospital. CC #133 confirmed discharge orders should have been communicated to the home physician for follow-up with the specified medication monitoring. CC #133 confirmed that in this case the licensee had failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of a resident so that their assessments were integrated and were consistent and complement each other.

13. During the stage one of the RQI, resident #004 triggered for choice lacking from a family interview. According to the SDM, the home had kept the resident in bed for the past few months because of an alteration in the resident's skin integrity.

Resident #004 had an alteration in skin integrity and was observed to be on complete bed rest for consecutive identified dates. Record review showed that the Enterostomal Registered Nurse (ET RN) wrote an order for 'total bed rest for seven days' on an identified date; however subsequent consult reports by the ET RN during scheduled

visits on two other identified dates showed to continue with bed rest and promote two hours repositioning. For approximately three to four identified months the resident remained on total bed rest.

During an interview with the physiotherapist, he/she stated that residents should not be on total bed rest nor left sitting up in a chair for extended periods. During an interview with the family on an identified date, the substitute decision maker (SDM) stated that they had requested that the resident be up in the chair for a short period each day so that the resident may be taken to the dining room for at least one meal daily and participate in activities with other residents on the unit. The SDM also stated that the resident preferred to be up in the chair so that she/he was able to enjoy the social aspects of living in the home.

During an interview, the ADOC, who was also the skin and wound care program lead, informed the inspector that the resident must be kept on complete bed rest to support healing of the impaired skin integrity. The ADOC also made the decision to keep the resident on total bed rest despite the substitute decision maker's and physiotherapist request to mobilize the resident by getting him/her up in the chair.

14. The Toronto Service Area Office (TSAO) of the Ministry of Health and Long Term Care (MOHLTC) initiated inspection Log # 026483-16 on an identified date related to the home's complaint of multiple incidents of responsive behaviors for resident #027.

Record review showed that resident #027 had identified responsive behaviors. A review of the records also revealed that the resident had a history of engaging in an activity outdoors; and that since readmission from an extended stay in hospital, he/she was not able to go outside for independently. Interviews and record reviews revealed that during this time, the resident displayed inappropriate responsive behaviors towards other residents and staff in the home.

A referral was made and the resident was assessed and followed by the an external resource team until an identified date; and an additional external team which was still ongoing. Record review indicated that on separate occasions and in a collaborated meeting, these team and the residents substitute decision maker informed the home's interdisciplinary team that the trigger for the resident's responsive behaviors was the need to engage in the identified outdoor activity, and the inability to go outside independently. The external teams recommended that the home assigned a one to one personal caregiver to support the resident's care and accompany the resident outside for

the activity; and the SDM also supported this strategy.

During an interview with registered staff #146, he/she stated that the home had provide 1:1 PSW support for the resident; however, the 1:1 PSW coverage was provided for only a few shifts, inconsistently, and the time period was of short durations. According to the registered staff, the episodic and sparse 1:1 PSW schedule led to increased episodes of inappropriate responsive behaviors when the resident was informed by staff that there was nobody available to accompany him/her outside.

A review of the progress notes revealed that in an identified month and with the support of the physiotherapist, the resident developed the skills to self-propel in the wheelchair to go outside independently; however, on numerous documented occasions, the staff would discourage the resident from going outside. During an interview, registered staff #146 confirmed that the home's DOC informed the direct care team to discourage the resident from going outside unsupervised, as was documented in the resident's plan of care.

During an interview with the DOC, he/she stated that if the staff did not allow the resident to go outside, he/she would display inappropriate responsive behaviors. The DOC also confirmed that the home did not follow the recommendation of the external resource team – the home did not have a discussion with the resident and SDM to develop a written contract related to the resident's safe practice; they did not consistently schedule/assign a 1:1 caregiver to support and accompany the resident outside; and they did not collaboratively develop a plan to ensure the safety of other residents in the home.

15. The licensee has failed to ensure that the substitute decision maker (SDM), if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

During stage one of the RQI, resident #004 triggered for choice lacking from a family interview. During the interview, resident #004's SDM stated that they attended the recent care conference and made the following request of the team: that the resident be transferred out of bed and into the chair for one to two hours daily so that he/she could attend scheduled activities on the unit; that the resident be taken to the dining room for at least one meal each day; that the resident be served a specific diet; and that the resident be provided a shower at least twice each week. The inspector observed that on multiple occasions during an identified month, the resident remained in bed all day, was fed a diet other than requested; and was served a pureed diet for all meals. During interviews,

registered staff #146 and PSW #128 confirmed these observations. During an interview, the home's clinical coordinator agreed that the substitution decision maker (SDM) input, as the resident's designate, choices and directions were not taken into consideration by the home in relation to the development and implementation of the resident's plan of care.

16. The Toronto Service Area Office (TSAO) of the Ministry of Health and Long Term Care (MOHLTC) initiated inspection Log # 026483-16 on an identified date related to the home's complaint of multiple incidents of inappropriate responsive behavior for resident #027. According to the intake, on an unidentified date during an identified month, resident #027 uttered threatening words with a sharp instrument towards another resident who resided in the home. The police were notified and had a discussion with the resident related to the incident. The home did not submit a critical incident to the MOH; although, as per the documents sent to the Minister by the home, this resident has had prior inappropriate responsive behavioral incidents which involved other residents and staff.

Record review showed that resident #027 has a substitute decision maker (SDM). Record review also revealed that resident #027 had two extended periods when he/she displayed inappropriate responsive behaviors in the home. The first period was identified over four months and was triggered by the resident's need to go outside to engage in an activity; but was being prevented from going outside by staff.

During an interview with the SDM, he/she stated that he/she requested if the home could provide a 1:1 PSW to provide care and support the resident going outside that would resolve the issue of the inappropriate responsive behaviors. He/she also told the home to allow the resident outside, but indicated that the staff kept discouraging and preventing the resident from going outside because they were afraid the resident would become unwell outside while by him/herself.

Record review showed that the second period of inappropriate responsive behaviors was identified over a period of two to three months during identified months; and that incident was triggered by the resident's refusal to receive tray service following an altercation with another resident.

During an interview, the resident's substitute decision maker (SDM) stated that he/she was not informed by the home of the change in resident's meal service; and that he/she heard about these changes from another family member and not from the staff in the

home.

During interviews with registered staff #146 and #131, both confirmed that they were aware of the triggers for both episodes of inappropriate responsive behaviors by the resident. Furthermore, both staff were aware that the resident's SDM was in favor of letting him/her go outside to engage in the activity independently, however the DOC #106 did not want the resident to go outside without supervision. Registered staff #146 also confirmed that the home did not inform the SDM of the changes related to the meal service for the resident and that the SDM should have been informed of both incidents.

During an interview with the DOC, he/she stated that registered staff members were expected to follow up with the SDM related to care and service changes; and that the staff were also expected to include the SDM in decisions regarding the resident's care.

17. 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 Critical Incident Report (CIR) was submitted to MOHLTC on an identified date related to an incident that caused an injury to a resident for which the resident was taken to a hospital and which resulted in a significant change in the resident health status. According to the CIR resident #012 who walked independently with a mobility device had a fall on an identified date in the hallway near the nursing station. The resident was transferred to hospital and had a procedure for a sustained injury.

A review of the resident #012's fall risk assessment from an identified date indicated the resident was at moderate risk for falls. The post fall assessment history before the incident on that identified date, indicated the resident had three additional falls prior to this. After the last fall on an identified date, the resident was assessed by the Physiotherapist on the same day, who documented in resident #012's progress notes that he/she informed the nurse on the unit to follow up regarding the resident's improper footwear. The post fall assessment note from another recent fall on an identified date also indicated the resident had improper footwear. A review of the post fall assessments on subsequent dates indicated the resident had improper footwear.

Interview with registered staff #126 indicated when a family member or substitute decision maker was to be contacted the expectation was that the communication was documented in the progress notes under the family communication tab. A review of the family communication notes did not indicate that the family was contacted in regards to

providing proper footwear for the resident. Interviews with the contacts in the resident chart indicated they were not contacted and informed that resident #012 needed proper footwear. Interview with the Social Worker (SW) indicated that if a resident required new shoes and he/she does not have a trust account in the home, then the home would try donations. The SW further revealed he/she was not aware that resident #012 required new shoes. Interview with registered staff #126 indicated that staff could also contact the home's Resident and Family Relation Coordinator in cases where they were not able to reach the family.

A review of resident #012's clinical record and interview with registered staff #126 and social worker confirmed that the recommendation from the physiotherapist was not followed up.

18. During Stage one of the RQI inspection resident #010's vision was triggered for not having visual correction. A review of resident #010's MDS assessment from an identified date indicated the resident had a vision impairment and did not wear a visual appliance for correction.

A review of the resident #010's clinical record revealed that on an identified date, the resident was assessed by a medical doctor who advised that the resident required consultation with a specialist. An interview with registered staff #104 revealed he/she could not find a referral sent to the specialist; and when the resident was asked by this staff for consent, the resident told the staff that he/she was waiting for that appointment to be arranged for long time. The registered staff sent the referral to the specialist after he/she was alerted to the incident by the inspector.

19. A complaint was submitted to MOHLTC on an identified date that a resident in a specified room was seen engaged in an identified behavior in the room on a specified date. According to the complaint the behavior in the specific resident's room was brought to the attention of staff but the situation continued to occur.

According to resident #017's assessment report on an identified date, the resident was referred for assessment because he/she was noted to be engaged in a behavior in his/her room on a specified date. The recommendation from the external team was for the home to involve the Social Worker and consider developing a contract with regards to privileges and responsive behaviors. The home was to make the resident aware of their policies in regards to engaging in the behavior on the premises. The contract should be agreed and signed by the resident; and a copy of the contract was to be provided to the

resident for future reference.

An interview with the Social Worker (SW) confirmed that the contract was developed in collaboration with the home's Administrator; however a review of resident #017's clinical record and interviews with registered staff #114 and the SW confirmed that the contract was not signed with resident #017 as per the external team recommendations.

20. During Stage one of the RQI, resident #004 triggered for skin and wound related to an alteration in the resident skin integrity revealed during the staff interview and census record review.

On an identified date and time the inspector observed that during a dressing change for resident #004 registered staff #126 dismissed PSW #128 when he/she attempted to assist with repositioning and holding the resident in place. The registered staff proceeded to use the back of his/her elbow/arm to secure the resident over in the required position so that he/she could perform the dressing change. The resident moaned uncomfortably during the procedure. Record review revealed that the resident's care plan listed bed mobility with two persons to provide total assistance. After the procedure, registered staff #126 stated that he/she should have accepted help from the PSW to support the resident's position. During an interview, the clinical coordinator #133 stated that the registered staff should have provided care to the resident as specified in the care plan.

21. The licensee has failed to ensure that staff and others who provide direct care to a resident was kept aware of the contents of the plan of care and given convenient and immediate access to it.

An interview with registered staff #104 revealed he/she had no knowledge of whether yearly dental assessments were being completed for residents, and if so, where the assessments were filed. The following day the registered staff discovered that the dental assessment forms were kept in DOC's office. The dental assessment form indicated resident #010 had specified diagnosis which required attention. The resident had complained of general discomfort and required a referral to a dentist.

Further interview with registered staff #104 indicated after the staff became aware of the dental assessment report, the resident was referred to dental services for which he/she consented.

22. The licensee has failed to ensure that a resident was reassessed and the plan of

care reviewed at any time when the resident's care needs change.

Review of SAC report submitted on an identified date revealed resident #046 was in his/her resident room resting in bed when he/she had an altercation with resident #045 causing altered skin integrity. The report stated resident #045 was likely confused and believed that this was his/her room which led to the altercation with resident #046.

Review of progress note from an identified date, documentation entered by RPN #117 revealed resident #045 was observed lifting a mobility device during an altercation with another resident after breakfast.

Interview with RPN #117 revealed resident #045's typical behaviors included inappropriate responsive behaviors with staff and resistance to care. RPN #117 stated resident #045 also exhibited behaviors of wandering on the unit, entering other resident rooms and lying down in other resident's beds. RPN #117 revealed that the resident's inappropriate responsive behavior of threatening other residents with the mobility device was a new behavior for resident #045, because he/she had no history of displaying this behavior with other residents prior. RPN #117 agreed resident #045's plan of care should have been reviewed and updated as this new behavior.

Interview with DOC revealed the expectation for the home was to reassess and review a resident's care plan when care needs change. He/she confirmed that as resident #045 was exhibiting a new behavior his/ her care plan should have been reviewed due to this change. DOC also confirmed that in this case the licensee had failed to ensure that a resident is reassessed and the plan of care reviewed at any time when the resident's care needs change.

23. During stage one of the RQI, resident #004 triggered for personal support bed-fast by the home's Minimum Data Set; and no activities of daily living assistance.

A review of resident's records reveals the following: the care plan with an identified date stated that for diet intervention the resident goes to the dining room;and for bathing intervention the resident was provided a shower twice weekly. The inspector observed that the resident was on complete bed rest and received tray service for all meal during identified dates in an identified month.

An interview with PSW # 128 and registered staff #126 revealed that the resident had been on bed rest since an identified month when the entero-stomal nurse wrote a consult

note recommending that the resident be kept on total bed rest for seven days because of an alteration in skin integrity, but that the care plan was not updated to reflect the same.

During an interview with the clinical coordinator #133, he/she stated that the expectation was for residents' care plans to be revised and updated to reflect the care being provided.

24. A review of SAC report which was sent to the MOHLTC on an identified date related to resident #027's altercation with resident #028 by uttering threatening words.

Record review revealed that on an identified date, resident #028, who was his/her own SDM, declined services from an external resource although informed he/she may benefit further from the team's support. During an interview with registered staff #146, he/she stated that resident #028 continued to exhibit responsive behaviors such as refusal of care and verbal altercations with other residents and staff. A review of the resident's plan of care indicated that the resident was still being followed and supported by an external resource although the progress note revealed that the external service was deactivated by the resident a month ago. Registered staff #146 confirmed during an interview that the resident plan of care was not revised and updated when the care needs changed.

25. The licensee failed to ensure that resident #027 was reassessed and that the plan of care were revised because care set out in the plan had not been effective and different approaches were not considered during the revision of the plan of care.

The Toronto Service Area Office (TSAO) of the Ministry of Health and Long Term Care (MOHLTC) initiated an inspection with an identified number on an identified date related to the home's complaint letter to the Minister stating multiple incidents of inappropriate responsive behavior by resident #027.

Record review revealed that on an identified date, resident #027 was told that he/she would be provided room service for all meals because of an altercation which occurred on an identified date with another resident. Interviews with registered staff #131, #146, and the DOC revealed that the dates and times of the resident's first and second incidents of tray service were not accurately documented. However, a review of the resident's progress notes revealed that the resident was offered tray service for an extended period of time for a period of approximately two months.

During interviews with registered staff #131 and #146, both stated that during both

periods of tray service, the resident displayed inappropriate responsive behaviors towards staff and other residents in the home, was resistive to care, and on many occasions refused to take his/her medications. Both staff also confirmed that the Director of Care used the same intervention to overcome the resident's inappropriate behaviors despite the resident's unresponsiveness to the intervention.

During an interview with the DOC, he/she stated that the resident was offered tray service multiple times; and that he/she told the resident that if he/she was good they would be taken off tray service. The DOC also confirmed that he/she used that intervention as a negotiation strategy; but that neither an assessment nor a reassessment of the use of that intervention was completed.

***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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the residents;***
***to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences;***
***to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other;***
***to ensure that the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care;***
***to ensure that the care set out in the plan of care is provided to the resident as specified in the plan;***
***to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it;***
***to ensure that a resident is reassessed and the plan of care reviewed at any time when the resident's care needs change;***
***to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary; and***
***to ensure that the resident is reassessed and that the plan of care is revised because care set out in the plan has not been effective and different approaches are considered during the revision of the plan of care, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**
**3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.**
**4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to stairways and to the outside

of the home be kept closed and locked, equipped with a door access control system that was kept on at all times, and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

On an identified date, the inspector observed resident #032 who resided on a ground floor unit wandering aimlessly in the stairwell on the that same floor, which was to be secured by a locked doors. On another identified date, the inspector also observed resident #045 who resides on another ground floor unit wandering in the same stairwell on the first floor. A review of both residents' records revealed that both residents wandered on their first floor units and wore wander-guard bracelets. The door in that stairwell area led to outside the home and directly into the parking lot. It was observed that the door had a secured entry code for staff entering the building from the outside; however, to exit the home from the inside there was no exit code. The exit required a light push on the door when leaving the building. Therefore, both residents could have potentially eloped from the home and wandered into the parking lot since the door was located inside that same stairwell where they had been found wandering.

The inspector and Environmental Service Manager (ESM) #167 observed that the stairwell door opened with a soft push on the exit bar. The inspector also observed, and the ESM confirmed that residents who smoke from both ground floor units, used that exit to leave the building. The ESM further stated that both residents must have wandered out of their assigned units when one of the other resident's who smoke exited the home to go outside for smoking.

During an interview with the Director of Care #106 and Administrator #100, both acknowledged their awareness that the staff entrance/exit door may be accessible by residents who wanders into the stairwell between the two units on the ground floor; and that such residents were at an increased risk of elopement from the home.

2. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and were kept closed and locked when they were not supervised by staff.

Observation by the inspector on an identified date, during initial tour of the home on an identified home area a door labeled laundry chute was observed to be unlocked and unsupervised by staff at the time of observation.

Interview with RPN #127 confirmed that the expectation of the home is for this door to be

closed and locked when not in use by staff. RPN #127 stated this door is accessed by PSW staff by using a coded keypad, he/she was not aware the keypad was malfunctioning.

Interview with Environmental Services Manager (ESM) #167 revealed that the coded keypad lock on this door was broken, and needed to be replaced. ESM #167 confirmed that this door should remain closed and locked when not in use by staff in order to prevent residents from accessing the laundry chute. In this case the licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and were kept closed and locked when they were not supervised by staff.

***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 all doors leading to stairways and to the outside of the home be kept closed and locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation; and to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and are kept closed and locked when they are not supervised by staff, to be implemented voluntarily.***

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**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 calls could be cancelled only at the point of activation.

The home's resident-staff communication and response system was equipped with a call bell system which displayed a light above the resident's room door simultaneously with an audible sound in the nurses station and hallways. On an identified date, the inspector observed that registered staff #126 pushed a button on the wall panel in the nursing station which stopped the audible sound that accompanied the visual light above a resident's bedroom. After silencing the sound at the nursing station, the registered staff called out to PSW #130 to check the resident in the room. During an interview, PSW #130 informed the inspector that staff usually silence the call bell sound at the nursing station, however the light above the resident's room door remained illuminated until it was cancelled inside the resident's room at the point of activation.

The ESM #167 stated during an interview that staff should not be silencing the alarm on the wall panel; and that they had covered the panel on another unit to prevent staff from accessing a similar button to silence the sound. During an interview with the Clinical Coordinator he/she stated that staff were expected to go to the residents' room and check the resident who was calling before cancelling the call bell at the point of care; and that staff should not be silencing the sound at the nurses station.

***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 calls could be cancelled only at the point of activation, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and that it was complied with by all staff.

Record review showed that on an identified date, while sitting in a room, resident #028 asked resident #027 to return borrowed items. Resident #027 refused to return the items. During an interview, registered staff #146 confirmed that later during the shift, resident #027 uttered threatening words and made an inappropriate gesture to resident #028.

Registered staff #146 further stated that both residents were immediately separated to prevent further altercations, and that resident #027 was informed that the behavior was unacceptable. Both residents' progress notes revealed that additional altercations occurred between the two without injury. During an interview with registered staff #146, he/she stated that the incident was reported to the charge nurse on the unit, who reports all such incidents to management. In addition, the staff stated that management usually read the 24 hour progress notes and would have been aware of the incident.

During an interview with the DOC #106, he/she stated that registered staff in the home does not call and report to the Ministry of Health (MOH); and that staff call 911 police and document incidents in the progress notes. He/she further stated that management was responsible for calling the MOH and completing the critical incident. Registered staff #146, #127 and #114 stated during interviews that direct care staff do not have access to the home's policies on the units.

During interviews, the DOC and ADOC stated that the home was currently working to develop written policies since the change in ownership approximately one and a half years ago; and therefore staff do not have policies located on the unit.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written policy that promotes zero tolerance of abuse and that it is complied with by all staff, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to immediately forward written complaints that have been received concerning the care of a resident to the Director.

Record review of the home's complaint log revealed the home had received a written complaint from a family member on an identified date concerning care of a resident in the home. The complaint detailed concerns regarding care needs of the resident, as well as internal transfer of the resident within the home.

On an identified date an inspector under the Act communicated via e-mail with the Central Intake and Triage Team (CIATT) to confirm that the above mentioned complaint was not forwarded to the Director. CIATT triage team confirmed that this complaint had not been received from the home.

Interview with Administrator #100 revealed he/she was not aware of the requirement to forward written complaints concerning care of a resident to the Director. He/she confirmed that the licensee failed to licensee immediately forward any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

***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 immediately forward written complaints that have been received concerning the care of a resident to the Director, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director.

A Critical Incident Report (CIR) was submitted to MOHLTC on an identified date for a resident to resident alleged abuse. According to the report with an identified date and time, resident #035 was in an altercation with another resident from a different unit. Resident #035 uttered threatening words and used a mobility device to gesture to the other resident. The other resident told staff that resident #035 was showing him/her threatening gestures and stated that he/she felt threatened. Registered staff #139 escorted resident #035 back to the unit. The police were called and both residents were told to stay away from each other.

Interview with DOC revealed the Administrator was present in the home during the incident and tried to intervene. The CIR was submitted to MOHLTC four days after the actual incident that occurred on an identified date; and the DOC confirmed that the incident was not submitted immediately.

2. A Critical Incident Report was submitted to MOHLTC on an identified date related to an incident altercation which happened between resident #035 and resident #018 on an identified date. According to the incident report, resident #018 had been found by

resident #035 in his/her room, sitting on the bed; and resident #035 proceeded to engaged in an altercation with resident #018. During the altercation, resident #018 fell backwards on the bed, thereby not sustaining an injury. This incident was witnessed by a staff who reported to the charge nurse.

Registered staff spoke to resident #035 who admitted to the altercation and causing resident #018 to have a fall backwards on the bed. The staff also informed the inspector that resident #035 stated he/she had the right to do this if resident #018 was sitting on his/her bed since that was an absolutely a no-no. The police was called and attended the home. The police discussed the issue with the resident and suggested that resident #035 called the staff for help with removing resident #018 from his/her room next time; however resident #035 stated that he/she would take care of it themselves next time.

A second incident was also reported to the registered staff during the week-end, when resident #035 had another altercation with resident #018 causing him/her to fall to the floor.; however that incident was not witnessed by anyone. However, resident #035 was the only resident near resident #018 when he/she was found on the floor.

A review of the CIR and interview with DOC confirmed the incident had occurred and management was aware, however it was reported to MOHLTC one day later.

3. A review of resident #035's clinical record revealed an altercation with resident #019 on an identified date. A review of Critical Incident Reports revealed a CIR was submitted on an identified date. According to the CIR the night PSW heard yelling down the hall and when he/she checked what was happening, resident #035 and resident #019 were yelling at each other. During the altercation, resident #035 engaged resident #019 who fell backwards; and resident #035 did not allow resident #019 to use the shared washroom. The PSW took resident #019 to anther washroom, then assisted the resident back to bed. The PSW did not report the incident to the charge nurse because no one was injured and resident #019 settled back to sleep. The incident was not revealed until resident #019's POA informed the registered staff and the police were contacted.

A review of the CIR and interview with DOC confirmed the incident had occurred but that it was not reported to MOHLTC immediately.

4. While conducting a record review for resident #023, the progress notes revealed evidence of inappropriate advancements made by resident #023 towards resident #030. Record review revealed that over an identified period of months, resident #030 was

subjected to multiple episodes of inappropriate advancements by resident #023. Interviews with PSW #175 and registered staff #156, #162, and #150 confirmed that all documented incidents stated in the progress notes actually occurred. Registered staff #150 and #156 informed the inspector that these incidents were reported to management and that it was up to management to report the incidents to the Ministry. Both staff confirmed that they received training related to abuse, and both identified that resident #023's responsive behaviors directed towards resident #030 were considered inappropriate advancement or abuse.

During an interview with the DOC #106 and the Clinical Coordinator #133, both acknowledged that they were aware of these incidents; however the DOC stated that it happened a long time ago and he/she could not recall if they reported these incidents of abuse to the Ministry. He/she further stated that it depends on the level of risk and the harm that was afflicted. The DOC also stated that resident #030 did not resist the actions, therefore it meant that he/she accepted the advancements since he/she did not protect themselves when approached by resident #023. Furthermore, the DOC stated that without resistance, it was considered accepted. The inspector searched the Critical Incident Report System but did not locate a report from the home related to any of the identified incidents.

***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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director; and***
***to ensure that abuse of a resident by anyone was immediately reported to the Director, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**

**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,**
**(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).**
**(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).**
**(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).**

**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 there were written approaches to care developed to meet the needs of the residents with responsive behaviors that include screening protocols, assessment, reassessment, and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other.

A Critical Incident Report (CIR) was submitted to the MOH on an identified date. The report documented that on an identified date, the charge nurse was alerted to come to resident #023's room where resident #024 was observed on the floor. The report showed that when asked what had happened, resident #023 described an altercation between self and resident #024. Resident #024 fell to the floor and that caused the resident to be transferred to hospital for assessment and a procedure. The report continued to note that resident #024 does wander into other residents' rooms and was sometimes found sleeping in other residents' beds.

Record review revealed that resident #023 was identified as having two responsive behaviors; he/she was very territorial and does not like others to enter his/her room; and he/she had a history of inappropriate advancements towards other residents on the unit. A review of resident #023 progress notes showed evidence of both behaviors towards one specific resident on the unit. Record review also revealed that although the interdisciplinary team were aware of the resident's responsive behaviors, there were no documented evidence and use of screening protocols, formal assessment, reassessment or behavioral triggers identified for either responsive behaviors.

During an interview with registered staff #150, he/she stated that registered staff do not have access to the home's responsive behavior policy or protocols for referral and treatment of residents who displays responsive behaviors. The registered staff continued by stating that he/she usually informs the attending physician about the residents' behaviors; and that the physician usually decides the next steps.

During an interview with registered staff #150, he/she stated that they first became aware of resident #023 inappropriate advancement behaviors during the admission care conference back in an identified date, when the family disclosed the resident's history

prior to admission. The registered staff also stated that he/she decided to protect the resident's privacy by not visibly documenting the information in the care plan. Although the incidences were reported to the physician and the resident was treated with medication, the resident behaviors were not included in the past or current behavior plan of care.

During an interview with the home's DOC #106 and Clinical Coordinator #133, both acknowledged that they were aware of the resident's identified responsive behaviors and that the information should have been documented in the resident plan of care.

2. The licensee has failed to ensure that resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviors.

A review of the Responsive Behaviors policy, NM-II-R007, dated April 2016, indicated the RN/RPN was to arrange for someone to have regular visits with the resident as a therapeutic measure, if possible.

Interview with registered staff #114 revealed when a resident was noted to have responsive behaviors, the physician would be notified in the physician's book or during his/her visit; and the physician would decide where to refer the resident for further assessment. Interview with DOC and ADOC indicated the PSWs should report responsive behaviors of residents to the registered staff and the registered staff would further decide about referring the resident to the physician. The question related to if the expectation from PSWs to report behaviors to registered staff was described in the policy, DOC and ADOC replied that it was not in the policy, and that the policy was still in the process of finalizing.

Interview with SW indicated he/she was not informed about resident #017's external resource recommendation from an identified date, to develop a contract.

Interview with registered staff #104 revealed he/she was not informed about the strong odor in resident #017's washroom and the suspicion that the resident was engaged in behaviors in his/her washroom by the cleaning staff. The cleaning staff reported the incident to the inspector previously that he/she smelled an odor but that he/she did not report it because everybody was aware of it.

Interview with registered staff #104 indicated he/she was not aware that resident #035 waved his/her mobility device when wandering residents were trying to enter his/her

room. When PSW #123 was asked what was the responsive behavior of resident #035, he/she stated that they did not want wandering residents to come into his/her private space and that he/she had seen the resident waving the mobility device when wandering residents were trying to get into his/her shared room private space. The PSW further stated that he/she did not report this behavior to registered nurses because everybody was aware of this behavior.

3. The licensee has failed to ensure that home's programs and services were coordinated and implemented on an interdisciplinary basis.

A CIR was submitted to MOHLTC related to a fire on an identified date and time in the hallway at the employees entrance of the building. Further the CIR revealed that the environmental services manager (ESM) was in contact with the fire marshal who recommended that the suspected resident should be referred for an assessment to an external resource team and to be followed up for his/her behavior.

A review of the Responsive Behavior policy, NM-II-R007, dated April 2016, revealed in the section for dealing with resident responsive behavior events, section 3 investigating, the registered nurse (RN) or registered practical nurse (RPN) will implement referral and review any recommendations from the Psycho-geriatric Team, Psychiatrist, Mental Health Worker, etc. The follow up section revealed the RN/RPN will work with the members of the interdisciplinary care team including the resident, family and any advocates to determine an appropriate plan of action to either alleviate the cause of aggression or to reduce the likelihood of it recurring. Consult Psycho-geriatric Team, Behavior Management Team, Psychiatrist, Mental Health Worker as required.

A record review for resident #017 revealed an assessment was conducted by an external resource team; and that if any issues or concerns arise to alert the team.

A review of resident #017's progress notes revealed that on an identified date and time, the resident was noted to be engaged in an identified behavior. The charge nurse asked the resident who denied.

Interview with ESM revealed that the resident was suspected in two previous incidents of causing a fire.

Interview with registered staff RPN #114 indicated he/she did not know if resident #017 should be referred for further assessment and that he/she had asked the advice of the

team members if the resident should be referred or not.

4. The licensee has failed to ensure that the responsive behavior program was developed and implemented in accordance with evidence-based practices or, if there are none, prevailing practices.

On an identified date, during an interview with the home's DOC #106 and ADOC #107, it was stated that the home's responsive behavior program was not fully developed and implemented. The DOC also added that they were in the process of scheduling panel meetings with internal and external stakeholders to form a Behavior Support Team (BST). The DOC further stated that the responsive behavior program did not currently have a lead; and that the education components were included in the electronic Surge Learning program but other arrangements were being made to schedule external education consultants to provide additional education for direct care staff.

The home provided the inspector with a Responsive Behaviors Policy and Procedure #NM-II-R007, with a listed effective date of April 2015, however multiple registered staff were interviewed, and the DOC confirmed that this responsive behaviors policy had not been made available to staff on the units in the home. The DOC further stated that that the registered staff on the units addressed the behaviors very well, that he/she does not need to be involved, and that the staff has resources they could call such as the Behavior Support Outreach Team (LOFT - BSOT), and the Geriatric Mental Health Outreach Team (GMHOT).

5. The licensee has failed to ensure that behavioral triggers were identified for the resident demonstrating responsive behaviors.

A Critical Incident Report (CIR) was submitted to MOHLTC on an identified date, related to an incident that caused an injury to resident #024 for which the resident was taken to a hospital and which resulted in a significant change in the resident health status. According to the CIR resident #023 engaged in an altercation with resident #024, which caused resident #024 to fall on the floor, transferred to hospital, and had a subsequent procedure for a sustained injury.

Resident #024 has an identified responsive behavior. Record review revealed that the home has engaged external resources to support assessment and interventions related to the resident's wandering behaviors including physician #179 and physician #180. Resident #024's chart contained resource documents on assessing for causes or triggers

and suggested interventions for those who engage in the identified behavior.

A review of resident #024's care plan does not identify possible behavioral triggers for the resident's behaviors, nor referred to the resource sheets listed above. During an interview with registered staff #150 he/she was aware of resident #023's identified behavior. The staff added that he/she was not aware of the resource documents placed in the resident's chart by the external team, and therefore did not use the forms to support assessment and identification of the resident's behavioral triggers. The resident was being monitored every 15 minutes, and was being re-directed when found in other resident's room. Registered staff #150 and the home's clinical coordinator #133 both stated during interviews that the resident should have been assessed and interventions set in place related to behavioral triggers identified for his/her.

6. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviors include assessments, reassessments, interventions, and that the resident's responses to interventions were documented.

A SAC report was received by the MOH related to an incident on an identified date where resident #027 was engaged in an altercation and uttered threatening words to resident #028.

Record review revealed that resident #027 had identified responsive behaviors with staff and other residents if he/she experienced a specific trigger. During an interview, registered staff #146 stated that the resident was offered room service because of an altercation with another resident; and that during that time period the resident displayed behaviors with other residents and staff in the home.

The home's documentation of the incidents were unclear; however a review of the progress notes indicated that on an identified date, the resident's room service was cancelled for a brief period and he/she went to the main dining room for meals, and was content and relieved to be able to eat and socialize with other residents. During an interview, registered staff #146 stated that he/she was then told by the DOC #106 a day or two later to resume tray service for resident #027 again because of a previous incident. During an interview, resident #027 stated that he/she was not told why tray service was resumed again by the staff; and also confirmed that he/she was not involved in a second incident of altercation. A review of the resident progress notes did not reveal the second incident stated by the registered staff nor was there any indication for the second episode of room service for the resident.

During an interview with the home's DOC #106, he/she stated that they did not have dates documented when the incidents occurred, but that the resident was started on tray service in an identified month after an altercation with another resident. The DOC also stated that the resident needed to work with the physiotherapy so that he/she could ambulate independently, and that putting the resident on tray service in his/her room was used as a strategy for negotiating with the resident. The DOC clarified that if the resident wanted to stop the tray service, he/she would have to behave and work with the physiotherapist. In addition, the DOC stated that they had planned to assess and reassess this strategy to control the resident's responsive behaviors, however the assessment and reassessment did not happen.  Record review and staff interviews confirmed that the home did not take actions to meet the needs of the resident with responsive behavior including assessment and reassessment, as well as accurate documentation related to these incidents.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are written approaches to care developed to meet the needs of the residents with responsive behaviors that include screening protocols, assessment, reassessment, and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other;***
***to ensure that resident monitoring and internal reporting protocols are developed to meet the needs of residents with responsive behaviors;***
***to ensure that home's programs and services were coordinated and implemented on an interdisciplinary basis;***
***to ensure that the responsive behavior program is developed and implemented in accordance with evidence-based practices or, if there are none, prevailing practices;***
***to ensure that behavioral triggers are identified for the resident demonstrating responsive behaviors; and***
***to ensure that the actions taken to meet the needs of the resident with responsive behaviors include assessments, reassessments, interventions, and that the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Critical Incident (CI) was submitted to the MOH by the home on an identified date. The CI showed that resident #023 told the registered staff that he/she was engaged in an altercation with resident #024 which caused resident #024 to have a fall, which resulted in a transfer to hospital and a change in the resident's health status.

Resident #023 had two identified responsive behaviors which were not assessed and included in the resident's responsive behavior plan of care. Record review and staff interviews revealed that the resident had two identified responsive behaviors. A review of the resident's progress notes showed evidence of those behaviors towards other residents.

Record review revealed that although the interdisciplinary team were aware of the resident's responsive behaviors, there were no strategies and interventions in place and included in the resident's care plan to minimize the risk of altercations and potentially harmful interactions between residents on the unit. During an interview with registered staff #150, he/she stated that they first became aware of the potential inappropriate behaviors during the admission care conference on an identified date; when the resident's family member disclosed their history. However, the staff stated that he/she was protecting the resident's privacy by not including the information in the plan of care.

The altercation between resident #023 and #024 resulted in an injury which required resident #024 having a procedure. Similarly, record review showed that resident #030 was subjected to inappropriate behaviors by resident #023 over a period of months on the unit. Registered staff #150 confirmed that in both incidents, steps were not taken to minimize the risk of altercations and potentially harmful interactions between these residents on the unit.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.***

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**WN #13: 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 were developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviors, including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of SAC report was sent to the MOHLTC on and identified date related to resident #027's altercation with resident #028.
Record review revealed that resident #027 had identified responsive behaviors if he/she

experienced a specific trigger. The records also revealed that the resident's behaviors were being followed by external resource teams with regular visits; and that both team assessed the resident and identified behavioral triggers/causes for the resident's inappropriate behaviors.

During an interview with the external resource nurse #155, he/she stated that some of their recommendations were adapted by the home, however there were some recommendations that was felt could have really helped the case, but they were not followed up by the home. One such example was when the team identified the resident's responsive behavioral trigger; the team noted that the resident was instead being discouraged and at times, prevented from engaging in the activity that would resolve the trigger, thereby causing the resident's inappropriate responsive behaviors to continue.

The inspector observed that resident #027 and #028 both accessed the same outdoor areas which was generally unmonitored by staff or management. Record review showed that that outside, unmonitored area was a common place where residents continued altercation after being separated by staff inside the home units. During an interview with the home's DOC #106, he/she stated that there was a discussion amongst the team to assign both residents to separate outdoor areas, however the plan was not enforced since resident #027 had refused to be moved to another outdoor area. Record review also revealed that the plan was not included in either resident's plan of care so that it could be implemented or follow up by staff.

A review of the external resource team documentation showed that prior to resident #027's series of altercations, a responsive behavior trigger had been identified. However the progress notes and interviews with PSW #130 and registered staff # 131 and #146 confirmed that the resident continued to be exposed to the identified trigger which promoted the inappropriate responsive behaviors for approximately two to three identified months.

During an interview with the home's DOC, he/she stated that the trigger was used as a strategy for negotiation with the resident where if he/she behaved and participated with the staff the trigger would be discontinued. In addition, the DOC stated that they had planned to assess the resident actions to this plan but that it did not happen.

***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 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 behaviors, including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.***

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (2) The food production system must, at a minimum, provide for,**
**(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).**

**s. 72. (4) The licensee shall maintain, and keep for at least one year, a record of,**
**(c) menu substitutions. O. Reg. 79/10, s. 72 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the organized food production system in the home at minimum provides for communication to residents and staff of any menu substitutions.

Observations on an identified date, in an identified resident dining room revealed the posted menu for lunch read Tuna Salad Plate, Sliced Cucumbers, Whole wheat bread. Upon observation of lunch service it was noted sliced tomatoes were being served to residents in place of cucumbers. PSW staff and residents had not been made aware of this substitution.

Interview with resident #044 during RQI stage one revealed that menu changes will take place without notification to residents. Resident #044 stated he/she kept a copy of the cycle menu which tracked these substitutions. Inspector reviewed this documentation

which revealed several changes to the menu.

Interview with resident #043 revealed that changes to the planned menu items occasionally occur, and that these substitutions are not announced to residents. Resident #043 stated the menu posting will say one thing and when the meal is served it will be something different, and residents are surprised by the substitution.

Interview with Food Service Manager (FSM) #101 revealed that the expectation of the home is to communicate any menu substitutions by changing the posted daily menu before posting. FSM #101 stated that the change on the above identified date, was not communicated to residents and staff and this appeared to be a mistake in the daily menu, which differed from the production sheets. FSM #101 confirmed that in this case the licensee has failed to ensure that the organized food production system in the home at minimum provided for communication to residents and staff of any menu substitutions.

2. The licensee has failed to maintain, and keep for at least one year, a record of menu substitutions.

Observations on an identified date, in an identified resident dining room revealed the posted menu for lunch read Tuna Salad Plate, Sliced Cucumbers, Whole wheat bread. Upon observation of lunch service it was noted sliced tomatoes were being served to residents in place of cucumbers.

Interview with Food Service Supervisor (FSS) #102 revealed that records of substitutions are not formally tracked on the production sheets by the dietary department. FSS #102 stated that if substitutions were made they would be changed on the daily menu to be communicated to residents.

Interview with Food Service Manager (FSM) #101 revealed a substitution would be made in cases when the purveyor was unable to supply an item, or an error in ordering was made. FSM #101 confirmed that a record of menu substitutions is not kept by the home, and was unaware of this requirement. FSM #101 confirmed that the licensee had failed to maintain, and keep for at least one year, a record of menu substitutions.

***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 organized food production system in the home at minimum provides for communication to residents and staff of any menu substitutions; and to maintain and keep for at least one year, a record of menu substitutions, to be implemented voluntarily.***

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**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).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

During the Resident Quality Inspection stage one interview, resident #004's SDM #183 stated that they reported three pieces of missing clothing to the staff in the home since an identified date. Record review showed that on an identified date the family brought in one non-descriptive housecoat; and on another identified date they brought in three pieces of clothing.

These items were documented on the home's Personal Clothing Form completed by staff or the family when new article of clothing were being sent to the laundry for labeling. During an interview with registered staff #131, he/she stated that they were not aware of the resident's missing clothing; and further, they had never seen the Lost Resident Clothing Policy # ENVP-0200 dated February 2016 nor the associated Complaint Forms shown to the staff by the inspector.

Registered staff #146 confirmed during an interview that the family complained to him/her directly regarding the missing clothing, however he/she did not complete the complaint form because it was not available on the unit. The staff further stated that they documented the family complaint in the electronic progress notes and assumed that a member of the management team would read the notes and follow up with the family regarding the missing items.

An interview with the Environmental Service Manager #167 revealed that he/she was not aware of the missing laundry nor the family's complaint related to missing laundry. The ESM was alerted to this incident on an identified date by the inspector. According to the ESM, he/she did not have a family report of missing clothing items in the home for over a year and a half; and he/she also stated that it is his/her belief that further training and re-orientation of forms and policy were needed for staff on all units to ensure implementation of the Lost Resident Clothing Policy, and the timely completion of all applicable forms to begin the process of recovery and communication with family.

2. The Licensee has failed to ensure that a documented record was kept in the home that includes: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant, any response made by the complainant.

Review of complaints submitted via Ministry Action line on two identified dates over a five-day period revealed resident #041 was having difficulty with another resident exhibiting behaviours which kept him/her up at night.

Record Review of Downsview Long -Term Care Centre complaint binder for an identified year revealed no record existed regarding resident #041's complaint. Review of progress notes revealed resident #041 had complained to RPN #146 on an identified date about a disruptive co-resident waking him/her up at night. Progress note from two weeks later revealed resident #041 had complained to RPN #153 about poor sleep due to disruptions by his/her roommate. Resident #041 subsequently complained
to Social Worker #119 on two consecutive dates one month following the initial complaint about the roommate's ongoing disruptive behavior.

Interview with resident #041 revealed he/she had complained to the staff at the home about a disruptive roommate disturbing his/her sleep at night. Resident #041 stated that the roommate was eventually moved, and that it took about a week to resolve the complaint.

Interview with Social Worker #119 revealed he/she had discussions with resident #041 regarding his/her complaint, and did not keep a record of these complaints. Social worker #119 stated this complaint was not able to be resolved within 24 hours as no beds were immediately available for the transfer.

Interview with the Administrator #100 revealed the expectation of the home is to keep a record of verbal complaints that are not resolved within 24 hours. Administrator #100 confirmed that with respect to verbal complaints the licensee has failed to ensure that a documented record is kept in the home that includes: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant and any response made by the complainant.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint; and to ensure that a documented record is kept in the home that includes: the nature of each verbal complaint, the date the complaint was received, actions taken to resolve the complaint, final resolution, dates communicating with the complainant, any response made by the complainant, to be implemented voluntarily.***

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**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (2) The licensee shall ensure,**
**(e) that a written record is kept relating to each evaluation under clause (d) 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. 229 (2).**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control program evaluation was kept that includes the following:

the date of the evaluation
the names of the persons who participated
a summary of the changes made, and
the date those changes were implemented

Interview with the IPAC leader revealed that on an identified date, the IPAC program leader updated the policy for tuberculosis screening according to recommendations from Toronto Public Health, TB prevention and control program an Tuberculosis Standards, seventh edition, 2013. The IPAC leader revealed there was no official annual evaluation of the Infection Prevention and Control (IPAC) program and was not able to demonstrate to the inspector a date of an evaluation, names of persons who participated, summary of changes made, and the date those changes were implemented.

2. The licensee has failed to ensure that all staff participate in the implementation of the infection control and prevention program.

During the initial tour of the home on an identified date and time, the Inspector was observing the shower room directly across from the unit one center nursing station. Inside the shower room the inspector observed an unlabeled, used, non-disposable razor on the top of a drawer system used to store resident nail clippers.

Interview with PSW #129 revealed that this razor should be labeled, and put away or disposed of after use. PSW #129 confirmed that this razor had been used by a resident. PSW #129 confirmed that this razor should have been labeled, and stored properly for infection prevention and control purposes. In this case the licensee has failed to ensure that all staff participate in the implementation of the infection control and prevention program.

3. During stage one of the RQI, resident #004 triggered for skin and wound for impaired skin integrity during a staff interview. On an identified date, the inspector observed that while completing a dressing change for resident #004, registered staff #126 neglected to clean his/her hands, change the gloves used to remove old dressing, and to clean the resident's skin before reapplying the clean dressing to the impaired skin area. During an interview with registered staff #126, he/she stated that they had forgotten it was required to clean their hands and change their gloves between the removal of old dressing and replacing the clean dressing to the impaired skin area.

During an interview with the Clinical Coordinator, he/she stated that proper infection

prevention and control techniques should be maintained at all time during skin impairment care procedure such as dressing change; and to avoid cross-contamination and infection the registered staff should clean the hands with hand sanitizer or by washing before and after such procedures. In addition, the coordinator confirmed that the registered staff should change the gloves once the soiled dressing was removed during the dressing change.

4. The licensee has failed to ensure that residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A review of the immunization records for resident #001, #009 and #010 revealed no immunization for tetanus and diphtheria. Interview with registered staff #104 indicated the home offers immunization against pneumoccocus but not for tetanus and diphtheria to residents during admission. The pneumoccocus immunization was listed on the admission checklist.

Interview with the ADOC, who was the leader of the infection prevention and control program, revealed the home does not offer tetanus and diphtheria immunization to residents unless they have actual cut or it was prescribed by the physician. The ADOC further stated that the tetanus and diphtheria vaccine was not available in the home's vaccine fridge.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record of the annual Infection Prevention and Control program evaluation was kept that includes the following: the date of the evaluation, the names of the persons who participated, a summary of the changes made, and the date those changes were implemented;***
***to ensure that all staff participate in the implementation of the infection control and prevention program; and***
***to ensure that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.***

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**WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the results of the abuse investigation was reported to the Director.

A review of the SAC incident revealed that on an identified date, an incident was reported to the MOH by the home. The SAC report showed that on an identified date, resident #027 engaged in an altercation with resident #028 and uttered threatening remarks and gestures to resident #028. The police was contacted and attended the home related to this incident. During an interview with the DOC, he/she stated that they informed registered staff #146 to contact the police to report the incident and threats made against resident #028. Although the DOC was aware that the incident had occurred and reported the incident to SAC, the home did not complete and submit a critical incident with the results of the investigation to the Director.

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

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

On an identified date, the licensee reported a critical incident to the MOH involving resident #014. A review of resident #014's plan of care did not indicate that the resident was assessed for his/her sleep pattern and preference. Interview with PSW #166 revealed that resident #014's preference during the day was to spend most of his/her time in bed and to rest after meals. The PSW also stated that if the resident was participating in activities, but decided to leave the activity because of disinterest, he/she was to be escorted to his/her room to rest instead. Interview with registered staff #104 revealed that because of the resident diagnosis, he/she should be escorted to and from the dining room, TV room, and all meals. The registered staff also confirmed that this routine was not documented in the resident's plan of care.

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**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

Record review of resident #005's Medical Administration Record (MAR) revealed an order for an identified oral nutrition supplement. Resident #005's MAR from an identified month revealed the order had been changed on an identified date as a result of a formulary change. The MAR showed that the administration of the identified nutrition supplement was completed and endorsed by registered staff for the remainder of the above mentioned month.

Review of resident #005's MAR for the following month revealed that the record of the administration of the identified nutrition supplement had not been endorsed by registered staff for the entire month. Review of the MAR for the third identified month revealed that no record of administration had been endorsed by registered staff for two weeks.

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Interview with RD #105 revealed that the resident was being followed quarterly by the RD. He/she further stated that during a nutrition assessment the RD would review the documentation in the MAR to evaluate supplement acceptance in order to determine the effectiveness of this intervention. In an interview RPN #103 stated that he/she was providing the nutrition supplement to resident #005 but had not documented it. He/she stated that the expectation of the home was to document the administration of this supplement in the MAR at the time that it was administered, or if the supplementation was accepted or refused.

Interview with RN #104 revealed that the expectation of the home was to record the administration of a physician ordered supplement at the time it was administered. RN #104 further stated that if the administration was not documented, it would be assumed that it had not been administered. In this case, by not documenting administration of ordered supplementation, the licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident of the home was bathed, at a minimum, twice weekly by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During stage one of the RQI, resident #004 triggered for choice lacking from a family interview. During an interview, resident #004's substitute decision maker stated that the resident enjoyed having a shower. The resident's care plan dated on an identified date, indicated that the resident's bath days were scheduled twice weekly with a preference for shower to be given in the morning. A review of the resident's bathing records, and interviews with the primary PSW #128 and registered staff #131 revealed that the resident was provided a bed baths for the past four weeks because the resident had an impairment in the skin integrity. Interviews with both staff revealed that staff believed the new shower chair in the home was unsafe for use by this resident in the shower room; although there was no assessment completed or documented by the physiotherapist of the home.

During an interview with the clinical coordinator #133, he/she confirmed that the last time the resident received a shower in the home was in identified month. He/she confirmed that the resident was not being bathed by their method of choice because the resident had an impairment in the skin integrity, and that the staff had complained that the shower chair was not safe for the resident to use for the shower, however an assessment was not yet completed.

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**WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The Licensee has failed to respond to the Family Council in writing within 10 days of receiving advice under paragraph 8 of s. 60. (1).

Record review of Family Council meeting minutes revealed the Family Council in the home had met three times over a twelve month period. Review of the meeting minutes from the Family Council meeting held on an identified date, revealed the Council had advised the licensee of concerns regarding the operation of the home. The Family Council members expressed concern about the home physicians not being receptive to the concerns of family members, and difficulty contacting the home physicians. No record of a written response to the Family Council was found relating to this advice.

Interview with Social Worker #119 revealed that these concerns from the Family Council had been brought forward to the Director of Care (DOC) regarding the home physicians. Social Worker #119 stated that these concerns from the Family Council meeting on the above mentioned identified date had not been addressed in writing. Social Worker #119 confirmed the expectation of the home is to respond in writing to advice from the Family Council within 10 days of receipt of the advice.

Interview with Administrator #100 confirmed that in this case the licensee had failed to respond to the Family Council in writing within 10 days of receiving advice under paragraph 8 of s. 60. (1).

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**WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

a) Observations of an identified resident dining room on an identified date, revealed resident #042 was in a slumped position while being fed by RPN #103. RPN #103 stated that resident #042 slides down in the chair and had been repositioned before lunch. Resident #042 was not observed to be coughing or choking while being assisted with feeding. Review of resident #042's written plan of care revealed he/she required monitoring, assistance and encouragement at meals. Subsequent observations of the above mentioned resident dining room eight days later revealed resident #042 was in a slumped position while being fed by RPN #158. The Inspector brought this to the attention of RN #104 who asked staff to reposition the resident. Interview with RN #104 confirmed that this was not a safe position for resident #042 to be fed in as it put the resident at risk of aspiration.

b) Observations of an identified resident dining room at an identified date and time revealed resident #036 was being assisted with feeding by PSW #160 while the resident was in a slumped position. No signs of choking were observed. Inspector brought this to the attention of RD #115, who asked staff members to reposition resident #036. Review of resident #036's written plan of care revealed that he/she required assistance for feeding and texture modification. Interview with RPN #114 revealed that resident #036 will slide down in the chair and exhibits identified behaviours when staff members attempt to reposition him/her. RPN #114 stated resident #036 had impaired skin integrity and had been assessed by the Physiotherapist. Interview with RD #115 revealed that resident #036 was not positioned safely while receiving assistance with feeding. In these cases the licensee has failed to ensure that the home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

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**WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

**Specifically failed to comply with the following:**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odors in the home.

During the period of the Resident Quality Inspection in the home, the inspector observed two main areas with persistent lingering odor. The hallway and surrounding area on the first floor close to the palliative room; and the hallway and surrounding area just inside the entrance of the secured unit. Interviews with housekeeping staff #141 and #178 revealed that they had tried various products available in the home to improve the odor in both areas. During an interview with the Environmental Service Manager #167, he/she stated that this had been an ongoing issue, that discussions were ongoing at the management level, and that they were planning to replace the tiles in those rooms. Further, he/she stated that they were currently testing a new product in the home related to odor control.

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**WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #030 substitute decision maker (SDM) was made aware of the alleged, suspected or witnessed incidents of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Record review revealed that on multiple identified dates over a period of months, resident #030 was subjected to multiple episodes of inappropriate behaviors by resident #023. During interviews with PSW #175 and registered staff #156, 162, and 150 confirmed that all documented incidents stated in the progress notes actually occurred. Registered staff #150 further confirmed that resident #023's family was informed of the incidents, however, resident #030's family was not contacted related to these episodes of inappropriate behavior toward the resident. The home's DOC #106 stated that registered staff usually report incidents to families if the resident was harmed.

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**WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**2. A description of the individuals involved in the incident, including,**
**i. names of all residents involved in the incident,**
**ii. names of any staff members or other persons who were present at or discovered the incident, and**
**iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**4. Analysis and follow-up action, including,**
**i. the immediate actions that have been taken to prevent recurrence, and**
**ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to immediately report the suspicion of abuse of a resident and the information upon which it was based to the Director.

A SAC report was received related to an incident which occurred on an identified date where resident #027 engaged in an altercation with resident #028's and uttered threatening words.

Record review revealed that resident #027 and 028 both go outside independently. A review of the progress notes revealed that on an identified date, resident #028 asked resident #027 to return borrowed items. Resident #027 refused to return the items; and at some point afterwards, resident #027 inappropriately gestured and uttered unkind words to resident #028. An interview with registered staff #146 confirmed that the incident did occur and that it was reported to the DOC #106. During an interview with the home's DOC, he/she stated that this incident which occurred on an identified date was not reported to the MOHLTC.

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: names of all residents involved in the incident, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.

A review of SAC report submitted on an identified date, revealed resident #027 engaged in an inappropriate altercation with resident #029 twice. The caller reported several concerns related to resident #027. Police was notified and they attended the home and spoke with both residents involved in the altercation. During an interview, the DOC #106 confirmed that he/she did not submit a critical incident report to the Director related to this incident.

3. The licensee has failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident Report (CIR) was submitted to MOHLTC on an identified date related to a resident to resident alleged abuse. According to the report on an identified date and time, resident #035 engaged in an altercation, uttered threatening words, and made unkind gestures to resident #015. Registered staff #139 escorted resident #035 back to the unit. The police were called and both residents were told to stay away from each other.

A review of the CIR revealed long-term actions that were planned to correct this situation was not submitted to the MOH. The MOHLTC requested the CIR to be amended with additional information such as: if the residents had a history of behaviors, and if so to describe including dates within the last three months and any injuries sustained and to include specific strategies and actions planned to prevent recurrence.

A review of resident #035's progress notes revealed on an identified date and time, the resident had an altercation with resident #015. Both residents were separated by staff to avoid further altercation. Interview with DOC revealed the CIR submitted on an identified date to MOHLTC was not amended with the additional information as requested.

4. A Critical Incident Report (CIR) was submitted to MOHLTC on an identified date, related to an incident that caused an injury to a resident for which the resident was taken to a hospital and which resulted in a significant change in the resident health status. According to the CIR resident #012 who ambulated independently with a mobility device, sustained a fall on an identified date and time, and that resulted in the resident's transferred to hospital, for a procedure related to a sustained injury.

MOHLTC requested the home to amend the CIR with additional information: history of falls including dates and injuries sustained in the last 3 months, family's response when notified of the incident, specific fall prevention plan and management strategies upon resident's return from the hospital.

A review of the resident #012's fall risk assessment on a specified date, indicated the resident was at moderate risk for falls. The post fall assessment history before the incident on an identified date, indicated the resident had falls on three other occasions. After the falls, on identified dates, physiotherapy assessments revealed that the resident was not wearing proper footwear. A review of further post fall assessments on identified dates, revealed that the resident had a total of eight falls.

During an interview with the DOC, he/she stated that not always when a critical incident report was submitted to MOHLTC that there was a request for additional information; and that the home usually responds to the request to update/amend the Critical Incident Report.

5. A review of an identified critical incident report revealed that on an identified date and time, a fire occurred in the hallway at the employee entrance of the home. The fire department arrived at the scene, but the fire was already extinguished by staff. The incident was reported to MOHLTC on an identified date and time.

MOHLTC requested the home to update/amend the CIR with specific strategies and

actions planned to prevent recurrence. The home amended the CIR on an identified date with the information that the Fire Marshall informed the environmental services manager (ESM) that the alleged resident could have an external team come into the home to speak with the resident and follow-up with the resident's behaviors. The external resource team would do a risk assessment and make recommendations for long term care and/or treatment of the resident. During an interview with the ESM, he/she stated that the Fire Marshall was not able to arrange for the external resource team to come into the home to speak with the resident and follow up with the resident's behaviors because the resident should be referred to external resources by his/her attending physician.

On the question about updating/amending the CIR with long-term actions planned to correct the situation and prevent recurrence, the DOC stated that it has been done by the Fire Marshall and called the ESM to confirm this in the presence of the inspector. At that time, the ESM explained to the DOC and ADOC that as per his/her best knowledge, the resident was not referred to the external resource team since the referral has to be done by the resident's attending physician.

6. A Critical Incident Report was submitted to MOHLTC on an identified date and time, about an incident for physical altercation that occurred with resident #035 and resident #018 on an identified date.

On an identified date, the incident report was amended with additional information. On an identified date, additional information was requested by MOHLTC.

A review of the CIR and interview with DOC confirmed the home did not update/amend the CIR.

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**WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**
**1. An emergency, including fire, unplanned evacuation or intake of evacuees.**
**O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed immediately, in as much detail as was possible in the circumstances, of an emergency, including fire, unplanned evacuation or intake of evacuees.

A review of a Critical Incident Report revealed that on an identified date and time, a fire occurred in the home at the employee entrance. The fire department arrived at the scene, but the fire was already extinguished by staff. The incident was reported to MOHLTC on an identified date and time. Interview with DOC and ADOC confirmed that the expectation was that a fire emergency was reported to the MOHLTC immediately, and that this incident was reported three days later.

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**WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply**
**Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:**
**1. All areas where drugs are stored shall be kept locked at all times, when not in use.**
**2. Access to these areas shall be restricted to,**
**i. persons who may dispense, prescribe or administer drugs in the home, and**
**ii. the Administrator.**
**3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On an identified date, the inspector observed PSW #130 entering the medication room in the home to get personal care supplies from the cupboard and to place/retrieve lunches in the small white fridge. The inspector observed that there was a cupboard labelled PSW Supplies and that there were two fridges in the medication room. During an interview with registered staff #127, he/she stated that if busy with other clinical duties, he/she would offer the medication room keys to PSWs and allow them to access personal care supplies from the cupboard in the medication room. During an interview the clinical coordinator stated that the expectation was that registered staff must keep the keys with them at all times and that PSWs were not allowed access the medication room for any reason.

**WN #28: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**
**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**
**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**
**2. The system must be ongoing and interdisciplinary.**
**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.**
**4. A record must be maintained by the licensee setting out,**
**i. the matters referred to in paragraph 3,**
**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**
**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that improvements made to the quality of the accommodation, care, services, programs and goods provided to residents were communicated to the Residents' Council, Family Council, and to the staff of the home on an ongoing basis.

On an identified date, the management team returned the Long Term Care Home Licensee Confirmation Checklist related to the home's Continuous Quality Improvement (CQI) & Required Programs to the inspector with question number three answered with a check mark placed between the yes and no boxes, and questions four and five answered no. The main focus of these three questions were related to communicating quality improvements outcomes, maintaining a record of quality improvements, and maintaining a record of the quality improvement program evaluation and the dates which quality improvements were implemented in the home.

The inspector reviewed the following home's records related to quality improvement

program: the Quality Improvement Plan (QIP) for Health Care Organizations in Ontario for 2015 and 2016, the resident satisfaction survey results completed on an identified date, staff satisfaction survey completed in on an identified date, complaints binder for 2015 and 2016, minutes from the Family Council on an identified date, minutes from the Resident Council on an identified date, and minutes from the Professional Advisory Committee on an identified date. The records revealed that there were no documented discussions related to quality improvements noted in the Resident Council, Family Council minutes, or staff meeting minutes.

On an identified date, the inspector conducted multiple interviews with staff members working in various departments in the home to assess their awareness of the quality improvement program and to elicit actions taken by the CQI committee to make improvements in the home. The following staff members were interviewed by the inspector: PTA # 179, registered staff #114, housekeeping staff #108, PSW #109, dietary staff #110, PSW #111, recreation staff #112, Director of Programs #113. Registered staff #114 and PSW #111 were vaguely aware of the CQI committee and equated the changes made by the committee to the newly developed staff driven FUN Committee. All other department members were not aware of what CQI meant or what was the purpose of the committee. During the interview with the Director of Programs #113 he/she was well aware of the program, and was able to describe the processes and committees associated with the CQI program. He/she also stated that the home did not have regularly scheduled meetings with the leads of these committees and therefore there were no documented records to communicate to everyone.

On an identified date, the inspector met with the home's Administrator #100, DOC #106 and ADOC #107 at which time the management team confirmed that members of the CQI program did not meet regularly and that meeting minutes were not documented. The team further stated that there was a gap in communicating improvements and changes made to programs and services in the home to the Resident Council, Family Council and to staff working in the home.

2. The licensee has failed to ensure that the home maintained a record of the names of the persons who participated in the evaluations, and the dates improvements were implemented.

On an identified date, the inspector met with the home's Administrator #100, DOC #106 and ADOC #107 at which time the management team confirmed that members of the

Continuous Quality Improvement (CQI) Program had not officially had a meeting, that the program was not formally evaluated with documented names of committee members, and that the home does not have recorded dates when quality improvements were implemented.

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**WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges**
**The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:**
**1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,**
**i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and**
**ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.**
**2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.**
**3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.**
**4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.**
**5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.**
**6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.**
**7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.**
**8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were not charged for goods and services provided without the resident's consent.

During a family interview, the SDM stated that on an identified date, resident #008 was provided a service by the home without the substitute decision maker's (SDM) permission or consent. Further, the resident's SDM was invoiced and charged an amount for the service provided as confirmed by the home's Junior Accountant #176. Registered staff #126 stated during an interview that the home did not have a process in place to notify staff when residents were scheduled for services off the unit. During an interview, the home's clinical coordinator #133 confirmed that there was a gap in the home's process for providing services to residents scheduled off the unit; and that the resident should not have been provided that service without the consent of the SDM.

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**Issued on this 27th 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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | VERON ASH (535), ADAM DICKEY (643), SLAVICA VUCKO (210) |
| **Inspection No. / No de l'inspection :** | 2016_324535_0006 |
| **Log No. / Registre no:** | 027286-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Feb 17, 2017 |
| **Licensee / Titulaire de permis :** | Downsview Long Term Care Centre Limited<br>3595 Keele Street, NORTH YORK, ON, M3J-1M7 |
| **LTC Home / Foyer de SLD :** | Downsview Long Term Care Centre<br>3595 Keele Street, NORTH YORK, ON, M3J-1M7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Christiana Burns |

To Downsview Long Term Care Centre Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

The licensee shall prepare, submit, and implement a plan that ensures that residents personal health information within the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act.

The plan shall include but is not limited to:

1. The development and/or revision of the home's policy related to the protection of residents' personal health information.
2. The completion of training and education for management and direct care staff related to the protection of residents' personal health information policy.
3. The development of a list of risk mitigating actions to be taken by the home to ensure residents' personal health information is not breached.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, March 6, 2017 via e-mail to:
veron.ash@ontario.ca.
Order / Ordre :
Page 3

**Grounds / Motifs :**

1. The licensee failed to fully respect and promote multiple residents' right to have personal health information (within the meaning of the Personal Health Information Protected Act, 2004) kept confidential.

A review of an intake with an identified date revealed that a personal health information package related to a resident was submitted to Minister Hoskins and parties at the Ontario Long Term Care Association (OLTCA) for review and response to a situation that was considered an urgent matter to the home.

On an identified date the home's Director of Care (DOC) #106 created a package which contained a compilation of a variety of medical and non-medical documents and forwarded the information to both the Minister and the OLTCA office. The package contained an introductory letter addressed to the Minister outlining their concerns regarding a resident in the home and that despite concerted efforts to address the concerns and behavioral issues with external support they have been unable to resolve them. Therefore, the letter was a request to refer the resident to an appropriate environment suitable to manage his/her behaviors and provide personal care.

During an interview with the DOC, he/she acknowledged sending the package to the Minister and the OLTCA. He/she also stated that they were urged by to find suitable placement for the resident; and that as a result of that request, they gathered all related documents, created a summary of incidents and events, and included all external resource information and hospital consultations to develop the package which was sent to the Minister. Furthermore, the DOC stated that they sent the package to the OLTCA because the organization was an advocate for the home. When asked directly if the resident's substitute decision maker (SDM) gave consent to send the package containing the resident personal health information to the Minister and the OLTCA, the DOC stated that the SDM did not specifically consent to send the package. However the DOC admitted that the package contained personal health information, and that there were concerns related to privacy and confidentiality especially because of the package sent to the OLTCA. When asked directly if he/she did anything to mitigate the consequences of disclosing the resident personal health information, the DOC stated that they did not believe it was a breach of confidentiality to send the OLTCA information so that they could review the resources available to the home.

During an interview with resident's SDM, he/she stated that they were not aware of a package containing personal health information was sent to the Minister or to the OLTCA. The SDM stated that permission was granted only to send the resident and personal information to another facility for assessment and

treatment so that he/she could be returned to the home.

On an identified date the inspector contacted the OLTCA and confirmed that they received the package sent by the DOC of the home, but that they immediately shredded the entire package except for the letter, which was kept because it was a letter from a member of the association.

On an identified date the home's Administrator was interviewed and he/she stated that the package was sent by DOC to the Minister and the OLTCA. The Administrator also stated that the person from the LHIN told them that the package also went to HRH, and he/she requested a teleconference call with the team to discuss the breach of privacy. On an identified date the Administrator also wrote a summary which stated that the breach of privacy would be considered a non-compliance incident that would need to be declared on the Compliance Declaration and requested an action plan related to the prevention of further privacy breach by the home in the future.

On an identified date, in his/her response to the email from the LHIN, the Administrator quoted paragraph 40 (1) under 'Disclosures related to risks' as a way of explaining the reason for the home sending the package in question to the Ministry of Health. The Administrator further apologized for any wrong doing related to the interpretation of the Act. He/she also stated that having sent the same package to OLTCA was wrong and the person responsible for the email has been spoken to; and as well, that he/she contacted the OLTCA and was assured that the package was destroyed. The Administrator informed the inspector that he/she wrote in an email to the LHIN to assure them that another breach would not occur in the future and that he/she would ascertain that all Management Staff closely working with personal health information would review the Personal Health and Protection Act and complete the annual Mandatory 3-part education segment on the electronic education program.

The scope of the non-compliance is patterned. The severity of the non-compliance is minimal harm/risk or potential for actual harm/risk. A review of the compliance history revealed a previous non-compliance (unrelated) was issued under inspection report # 2015_321501_0021 on October 29, 2014.

(535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 19, 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. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee shall prepare, submit, and implement a plan that outlines the implementation of the home's abuse and neglect policy to ensure that residents are not neglected or abused by anyone in the home.

The plan shall include but is not limited to:

1. The development and/or revision of the home's abuse and neglect policy to ensure that it is consistent with current practices and that the policy comply with the LTCHA, 2007.
2. The completion of education for management and direct care staff related to the abuse and neglect policy.
3. The development and/or revision of the home's mandatory reporting requirements policy to ensure that it is consistent with current practice and that the policy comply with the LTCHA, 2007.
4. The completion of education related to the mandatory reporting requirements for management and all direct care staff.
5. The development of quality management activities, including monitoring and evaluation, to ensure that the home's abuse and neglect, and mandatory reporting requirement policies are being complied with by all staff.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, March 6, 2017, via e-mail to:
veron.ash@ontario.ca.

**Grounds / Motifs :**

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

anyone and free from neglect by the licensee or staff in the home.

On an identified date, the home reported an incident of resident to resident abuse to the Ministry. According to the incident report, at an identified time during the shift, resident #035 was witnessed in his/her room by a staff member engaging in an altercation with resident #014. Resident #014 had wandered into resident #035's room; and according to resident #014's care plan, he/she needed redirection and supervision. The police was called, and resident #014 was transferred to hospital for assessment and treatment.

Interview with resident #035 revealed that he/she reported to the home about other residents entering his/her personal space; and indicated that the response from staff was ineffective in preventing this from occurring.

Interview with PSW #123 revealed that a few months ago, he/she saw resident #035 in his/her room waving the mobility device in the presence of another resident who attempted to enter the private space. During an interview, registered staff RN #104 revealed that the resident usually activate the call bell for staff to come and remove other residents from his/her room, however in this instance the resident did not call to have the resident removed.
(210)

2. The Toronto Service Area Office (TSAO) of the Ministry of Health and Long Term Care (MOHLTC) initiated an inspection on an identified date to inspect a related complaint sent by the home to the Minister. The complaint alleged multiple incidents of inappropriate responsive behaviors by resident #027 toward other residents and staff in the home.

Record review of the minimal data set (MDS) assessment tool revealed that resident #027 had impaired cognitive skills, poor decision making, and required supervision for care and treatments. He/she could independently ambulate with a mobility device and was able to go outside independently; and the progress notes showed that he/she had an identified behavior.

A review of the progress notes revealed that since an identified date, the resident was admitted to hospital multiple times related to his/her diagnosis. Following the longest period of hospital admission over a period of identified months, the resident was transferred back to the home without the ability to ambulate independently.

A review of the assessment records showed that an external resource team was consulted to help support the resident's responsive behaviors. The assessment records also revealed that the resident was displaying these behaviors towards staff and other residents in the home. The assessment record also showed that on an identified date, the resident's displayed responsive behaviors which the home did not support as recommended by the external resource team and the resident's family. On an identified date, the external resource team assessed the resident and recommended changes and adjustments to the resident's medications. The physician lead #180 also recommended that the home created a schedule to support the identified behavior.

On an identified date, the external resource team consultation notes read that the resident had some improvement in behavior but that he/she was displayed responsive behaviors to express a need. The external team again recommended that the home was to meet with the family and develop a plan related to the resident's identified behavior, and also create a plan to ensure the safety of other residents in the home.

On an identified date, the external term notes revealed that the resident repeatedly requested to go outside. During an interview with the resident's SDM #141, he/she stated that they were unable to support the cost of a private caregiver; and therefore requested help from the home to implement and support this intervention. During an interview with the external resource nurse #155, he/she stated that some of the team's recommendations were adapted by the home, however there were some recommendations that the external team felt could have really helped the case, but they were not followed up or implemented by the home. One such recommendation was the acknowledgement of the resident's responsive behavioral trigger. The external resource nurse also stated that during subsequent visits, he/she reviewed the progress notes and noted that the resident was being prevented from going outside which triggered continued inappropriate responsive behaviors.

During an interview, registered staff #146 confirmed that the home's Director of Care #106 did not want the resident to go outside because of the safety risk given the resident's recent diagnosis; therefore the resident's care plan listed an associated intervention to discourage the resident from going outside at the time. The registered staff also confirmed that the home provided one to one personal care support for the resident; however that intervention was provided

inconsistently and for short durations during for approximately three shifts.

During an interview with the home's Director of Care #106, he/she confirmed that they did not want the resident to go outside because of safety reasons. The DOC also confirm that the home did not discuss or create a written contract with the resident or the resident's SDM related to the resident's identified behavior; nor did they address the issue of safety for other residents in the home as recommended by the external resource team.
(535)

3. A SAC report was submitted on an identified date to the MOH which revealed that there was ongoing altercation between resident #027 and resident #028. It noted that resident #028 was going outside through a door pass resident #027 when he/she engaged resident #028 in an altercation while uttering inappropriate words.

A review of both residents' progress notes revealed that they both had identified responsive behaviors; and that they were permitted to go outside independently. A review of the progress notes also revealed that on an identified date, resident #028 refused to hold a door open for resident #027 and that sparked the beginning of a series of altercations between the two residents. According to the records, on an identified date, resident #028 asked resident #027 to return borrowed items and resident #027 refused. At a later time during the shift, resident #027 engaged in inappropriate responsive behavior and gestured towards resident #028 while uttering inappropriate words.

During separate interviews with registered staff #131 and #146, both confirmed that the incident occurred as documented. Registered staff #146 further stated that both residents were immediately separated to prevent further altercations, and that resident #027 was informed that his/her behavior was unacceptable. Both residents' progress notes revealed that additional altercations occurred between the two residents without injury.

On an identified date, the progress notes showed that resident #028 expressed feelings of unpleasantness when around resident #027 following the incident; and on another identified date, while resident #028 was exiting the door on the way outside, resident #027 engaged with him/her in an altercation and again uttered inappropriate words.

During an interview with the DOC, he/she stated that resident #028 came to the office to report the altercations with resident #027 and at that time, the police were notified and attended the home.

During an interview with resident #027, he/she stated that the words and gestures were supposed to be a joke and was not to be taken seriously. He/she stated that they just wanted to scare resident #028.

During the interview, registered staff #146 stated that the altercation between the two residents constituted abuse of resident #028. During the interview, the Director of Care #106 confirmed the incident was abuse of resident #028 by resident #027.

(535)

4. While conducting a record review related to another critical incident which involved resident #023, the inspector read a progress note which lead to the inspection of this incident. Record review revealed that resident #031 was cognitively impaired and non-communicable; and resident #023 was mildly impaired and independently ambulated with a mobility device. The progress notes showed that resident #023 had identified inappropriate responsive behaviors; and that on an identified date, resident #023 engaged in an inappropriate behavior towards resident #031.

During an interview with registered staff #150, he/she confirmed that the incident occurred as was documented with no harm noted to resident #031. The staff confirmed that management was made aware of the incident but that the police and family were not notified. During an interview with DOC #106 and Clinical Coordinator #133, both acknowledged that they were aware of the incidence; and the DOC confirmed that the incident was documented in the progress notes by the registered staff however the resident was not harmed and therefore the incident was not reported to the family or the MOHLTC.

(535)

5. While conducting record review related to a critical incident which involved resident #023, the inspector read a progress note which lead to the inspection of this incident. The progress notes revealed that resident #030 was assessed as moderate cognitively impaired; and has an identified behavior. He/she was

provided behavioral support through psychotropic medications and external resources. Resident #023 was mildly impaired and independently ambulated with a mobility device. Resident #023 also had an identified responsive behavior. Over an identified period of months, the progress notes revealed that resident #023 exhibited inappropriate responsive behaviors towards resident #030.

On an identified date, Physician #179 recommended that resident #023 be prescribed a medication to treat his/her inappropriate responsive behaviors. Although the identified responsive behavior had decreased, on another identified date after the treatment started, resident #023 had another inappropriate behavior towards resident #030.

Interviews with PSW #175 and registered staff #156, 162, and 150 confirmed that all documented incidents stated in the progress notes actually occurred. Both registered staff also confirmed that resident #023 directed inappropriate responsive behaviors towards resident #030 which constituted abuse. During an interview with DOC #106 and Clinical Coordinator #133, both acknowledged that they were aware of these incidents of inappropriate behavior towards resident #030. The home did not complete an assessment for either resident's ability to consent to these behaviors.

The home's DOC #106 stated during an interview that the behaviors were documented; and it depends on the level of risk and the risk that was afflicted in terms of reporting of such incidents to family or the Ministry of Health.

(535)

6. Critical Incident Report was submitted to the MOH on an identified date. The report showed that on an identified date there was an altercation between resident #023 and resident #024 in resident #023's room. Resident #024 had a fall which caused an injury requiring transfer to hospital, and a procedure was performed related to the injury. Record review showed that resident #024 has an identified responsive behavior; and he/she was sometimes found in other residents' rooms and/or sleeping in other residents' beds.

Record review and interviews with both staff confirmed that on an identified date, registered staff RN #150 was alerted by PSW #161 to visit resident #023's room immediately where the incident occurred.

During an interview, registered staff #150 stated that this was an incident of abuse committed by resident #023 during the altercation in his/her room. During an interview, the home's DOC #106 acknowledged the incident as an act of abuse towards resident #024.
(535)

7. Review of a Spills Action Centre (SAC) report for submitted to the Ministry of Health and Long-Term Care (MOHLTC), revealed resident #046 was in his/her room resting in bed when an altercation occurred with resident #045 which cause injury requiring treatment. The report stated resident #045 was likely confused and believed that this was his/her room which led to the altercation with resident #046 who was resting in his/her bed.

Interview with Recreation Assistant (RA) #169 revealed that on an identified date, at an identified time he/she was conducting a resident activity when a noise was heard from a nearby room. RA #169 stated he/she observed resident #046 coming out of the his/her room with an injury requiring assessment and treatment. RA #169 stated that there was an altercation between resident #046 and resident #045. RA #169 stated resident #045 was attempting to get in resident #046's bed, but that he/she escorted resident #045 back to his/her own room.

The progress note showed that according to resident #046 he/she was sleeping and resident #045 entered the room. Resident #046 told resident #045 to leave the room, which sparked the altercation between the two residents.
.
Review of a progress note entered by registered staff RPN #117 on an identified date approximately three weeks prior to the incident, revealed that resident #045 had been observed with responsive behavior towards a co-resident with the mobility device. Staff removed resident #045 from the area.

Interview with RPN #117 revealed he/she was unsure if resident #045 was serious when he/she was displaying responsive behavior towards co-resident as resident #045 liked to joke around. RPN #117 indicated that this was a new behavior for resident #045. RPN #117 stated that additional monitoring of resident #045's behavior was not initiated as a result of this new behavior.

Interview with RN #174 revealed that staff members on the unit were aware that

resident #045 had exhibited identified responsive behaviors. RN #174 stated that resident #045 was able to ambulate without the assistance of the mobility device. RN #174 was unaware of the incident of responsive behavior on the previously mentioned identified date.

Interview with the DOC revealed that he/she had not been made aware of resident #045's responsive behavior. DOC further stated that resident #045 should have had his /her behavior monitored and assessed by registered staff since that was a new responsive behavior. The DOC confirmed that in this case the licensee had failed to ensure that resident #046 was protected from abuse by anyone.

The scope of the non-compliance is patterned. The severity of the non-compliance is actual harm/risk. A review of the compliance history revealed an ongoing non-compliance with a VPC or CO. A CO was issued under inspection report # 2014_321501_0021 on October 29, 2014.
(643)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 19, 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

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**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee shall prepare, submit, and implement a plan that ensures that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with, and is implemented in accordance with all applicable requirements under the Act; and is complied with.

The plan shall include but is not limited to:

1. The development and/or revision of the home's responsive behavior, skin and wound, complaint, restraint, personal care, and medication administration policies to ensure that they are in compliance with, and are implemented in accordance with all applicable requirements under the LTCHA, 2007.
2. The completion of education for all applicable management and direct care staff related to the home's responsive behavior, skin and wound, complaint, restraint, personal care, and medication administration policies.
3. The development and/or revision of the home's process/protocol for the referral of internal and external resources available to support residents' responsive behaviors in the home.
4. The completion of education for all applicable staff related to the home's process/protocol for the referral of residents to internal and external responsive behavior resources.
5. The development of quality management activities, including monitoring and evaluation, to ensure the home's responsive behavior, skin and wound, complaint, restraint, personal care, and medication administration policies; and the process/protocol for internal and external referrals related to residents' responsive behaviors are complied with by all staff.
6.Ensuring nursing related policies are made accessible to all nursing units for reference by registered and direct care staff.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, March 6, 2017 via e-mail to:
veron.ash@ontario.ca.

**Grounds / Motifs :**

1. The licensee failed to ensure that the responsive behavior policy was put in place and implemented in accordance with all applicable requirements under the Act.

During interviews, registered staff #131, #146, #114, #126, #127, and #150

stated that they have not seen a responsive behavior policy in the home. During an interview with the home's DOC #106 and ADOC #107, both acknowledged that they have been in the process of developing the nursing program policies for the past year and a half; and confirmed that the policies have not been made available to staff on the units. (535)

2. The licensee has failed to ensure that the skin and wound, complaint, restraint, and personal care policies were put in place and implemented in accordance with all applicable requirements under the Act.

Registered staff #126, #150, #131, and #114 stated during interviews that they did not have access to policies applicable to skin and wound, complaint, restraint, and personal care policies on their units. During an interview with the home's DOC #106 and ADOC #107, both acknowledged that they had been in the process of developing the nursing program policies for the past year and a half; and confirmed that the policies were not put in place and implemented for direct care providers working in the home. (535)

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

A Critical Incident Report (CIR) was submitted to Ministry of Health and Long Term Care (MOHLTC) on an identified date related to resident to resident abuse. According to the incident report, at an identified time, resident #035 was witnessed engaged in an altercation with resident #014 who had wandered into resident #035's room. The staff member intervened to stop the altercation. The police were called and attended the home. Resident #035 was sent to hospital for assessment; and resident #014 was transferred to hospital for assessment and treatment.

A review of the policy "Responsive Behaviors" revised on an identified date, revealed a procedure for dealing with resident responsive behavior events. The RN/RPN would examine injuries and provide necessary treatment, interview all people involved including witnesses, investigate the situation with the interdisciplinary team by assessing the circumstances under which the behavior occurred in an effort to determine its cause. The team can involve others such as the manager, clinician, or a member of the joint health and safety committee. As part of the investigation, examine the following: resident's history and plan of care, environmental factors (noise, heat, cold), physiological factors (pain,

constipation, infection, change in blood sugar level, hunger/thirst, non-compliance with medication), social factors (loneliness, dispute with another person, recent life-altering event, fear, frustration), caregiver approach (whether person-centered, respectful, any change in routine), resident rights (privacy, personal space, basic needs met), implement referral and review any recommendations from the Psycho-geriatric team, psychiatrist, mental health worker.

A review of resident #035's progress notes revealed two incidents of responsive behavior of resident #035 towards other residents.

On an identified date and time, resident #035 had an altercation with resident #015. Both residents were separated by staff to avoid further altercation.

On an identified date and time, resident #035 had an altercation with another resident while uttering inappropriate words and gesturing with a mobility device. The other resident told the registered staff and the staff escorted resident #035 back to his/her unit. A CIR was submitted to MOHLTC on an identified date and the police were called.

A review of the clinical record indicated that the resident was assessed by an external resource team on an identified date, for responsive behaviors but there was no mention about the behavior towards the other resident with the mobility device.

Interview with PSW staff #123 revealed in the last few months the resident did not want anyone in his/her private personal space, and the staff had seen the resident displaying the mobility device to other residents who tried to enter his/her room.

Interview with registered nurse staff #104 indicated that the resident should have been referred to the external behavioral team after the incidents on that identified date, for further assessment of the behavior; and also confirmed that the resident was not referred.
(210)

4. The licensee has failed to ensure that medication administration policy was complied with.

A reviewed of an identified complaint log submitted to the MOHLTC on an identified date, revealed that a resident #037 was administered medication that was not warranted and not signed for.

On an identified date, resident #037 was administered medication as required. During an interview registered staff #145 stated that he/she administered the medication to the resident, but did not sign the medication administration record (MAR) immediately after administering the medication to the resident. Subsequently, the staff had forgotten to sign the MAR during the shift and left the facility at the end of the shift. After the interview, the staff was alerted to the omission of the signature and returned to the resident's MAR to sign on the applicable date and time. The home's Pharmacy vendor, implemented the Administration of Medication Policy # 7.2 As Needed (RPN) Medications with an identified revision date. A review of this policy revealed that registered staff was to document medications administered on the MAR for the corresponding date and time immediately for each medication administration. During an interview with the clinical coordinator, he/she confirmed that the registered staff did not comply with the pharmacy policy during the dated medication pass.

The scope of the non-compliance is patterned. The severity of the non-compliance is minimum harm/risk or potential for actual harm/risk. A review of the compliance history revealed no previous noncompliance.
(535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 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) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

**Order / Ordre :**

The licensee shall do the following:

1. Ensure that the height for each resident is measured and recorded annually.
2. Develop policies and procedures that clearly indicate the tasks and roles of each direct care staff to ensure that the annual heights are measured and recorded in the home's documentation system in a timely manner.
3. Develop an audit system in the home to ensure the annual heights are being completed.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, March 6, 2017, via e-mail to:
veron.ash@ontario.ca.

**Grounds / Motifs :**

1. The licensee has failed to ensure that for each resident height was measured and recorded annually.

Record review of residents from the Resident Quality Inspection stage one census sample revealed that a significant number of residents did not have height measured and recorded in the last year; and at least half the resident in the sample residents did not have a height measured or recorded in a three year period.

Interview with Registered Dietitian (RD) #105 revealed that he/she had been aware that resident heights were not being measured and recorded annually, and that he/she was more concerned with getting resident weights completed. RD #105 confirmed that heights were not measured and recorded annually, and that the expectation of the home was for heights to be measured and recorded on admission and annually thereafter.

Interview with the ADOC confirmed that the expectation of the home was to measure and record the height of each resident annually. He/ she confirmed that the licensee has failed to ensure that the height for each resident was measured and recorded annually.

The scope of the non-compliance is widespread. The severity of the non-compliance is minimum risk.
A review of the compliance history revealed a previous Voluntary Plan of Correction (VPC) was issued under inspection report # 2015_398605_0019 on December 3, 2015. (643)

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

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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 17th day of February, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Veron Ash

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