Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 22, 2017	2017_619550_0018	013359-17	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

JOANNE HENRIE (550), JOELLE TAILLEFER (211), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 21, 24, 25, 26, 27, 28, 31, August 1, 2, 3, 4, 8, 9, 10, 11, 14, 15 and 16, 2017

Logs # 005084-17, 012590-17, 012455-17, 017586-17, 015638-17 and 017157-17 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager for Resident Care (PMRC), the Program Manager for Personal Care (PMPC), the Recreation, Culture and Volunteer Manager, a Dietician, a Food Services Manager (FSM), a Nutrition Supervisor, a Housekeeping Manager, a Site Supervisor, a Staffing Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several Housekeeping Aide, a Cook, several Dietary Aides, a Unit Clerk, the president of the Resident Council, the President of the Family Council, several residents and several family members.

In addition, the inspectors reviewed resident health care records, policies related to restraints, complaint procedures, prevention of abuse, CIS reporting and resident council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **19 WN(s)**
- **14 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to minimize the restraining of the residents is complied with.

Inspectors #547 and #550 reviewed the home's restraint policy titled "Least Restraint", policy #335.10, revised January 2017. On pages 4 and 5, "Procedure: Initiation of Restraint" indicated the following:

1. Complete an assessment to determine rationale for considering a restraint. Potential for injury to self or others.
2. Ensure that all possible alternative interventions are attempted prior to applying a restraint (see restraint decision tree).
5. Obtain and document consent or refusal on consent form.
6. Before using, contact the physician and obtain an order for the restraint. The physician must review the restraint order quarterly, and more frequently as required.
7. Fax the physician order to Pharmacy so that the restraint order will appear on the MAR and the Quarterly Medication Review.
8. Document in the progress notes circumstances precipitating to the application of the restraint; alternatives considered and why inappropriate; person who made the order; what device was ordered; consent; person who applied the device and the time of the application.
9. Initiate the Restraint Monitoring Form. Ensure completion using the appropriate key and response.
13. Every release of the device and all repositioning will be recorded on the restraint/PASD flow sheet.
14. Document all assessments, reassessment and monitoring including the resident's response, as well as the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining.
18. The resident's condition is reassessed and the effectiveness of the restraining is evaluated every 8 hours by a member of the registered staff and documented on the MAR.

1. Resident #003 was admitted to the home in 2015 with several medical diagnoses. Resident #003 was observed by inspector #547 to wear a seat belt restraint while seated in a wheelchair on July 24, 25, 26, 27, 28 and 31, 2017.

On July 26, 2017 RN #100 indicated that the resident wears a seat belt restraint when in the wheelchair at all time for safety. RN #100 further indicated that registered nursing staff are responsible to record on the Medication Administration Records (MAR) every

shift when the resident is up in the wheelchair, that the seat belt restraint is properly applied and the resident is reassessed every eight hours. Inspector #547 interviewed RN #109 who indicated that the resident's seat belt restraint should have been recorded in the resident's MAR and then signed for every day and evening shift in order for the evaluation of the applied restraint. RN #109 further identified the home's plan of care to include the resident's care plan, PSW documentation flow sheets, Medication Administration Records (MAR), and the resident's physical and electronic health care records.

Inspector #547 obtained copies of the resident's MAR and observed that there was no documentation for any seat belt restraint identified on resident #003's MAR sheets for the month of July 2017. The resident health care records also did not have an order by the physician or the registered nurse in the extended class for the use and application of the seat belt restraint for resident #003.

RPN #140 indicated to Inspector #547 on July 27, 2017, that the resident had an old order form for restraint dated a specified date in 2015 in the chart signed by the physician. RPN #140 further stated that restraints are to be re-ordered every three months as per the home's policy for restraints and that this had not been completed for resident #003.

Inspector #547 reviewed resident #003's plan of care and no documentation regarding the circumstances precipitating the application of the physical device, what alternatives were considered and why those alternatives were inappropriate. It was noted that there was no order, what device was ordered, and any instructions relating to the order. There was no consent on file. There is no documentation regarding when the restraint was applied and by who or all assessment, reassessment and monitoring, including the resident response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

As such, the home's policy "Least Restraint" was not complied for resident #003's use of a seat belt restraint.

2. Resident #006 was admitted to the home in 2015 with several medical diagnoses. The resident was observed by inspector #547 to wear a seat belt while seated in a wheelchair on July 24, 25, 26, 28 and August 2, 2017.

On July 26, 2017 RN #100 indicated that resident #006 requires a seat belt restraint when in the wheelchair at all time for safety since the resident returned from hospital on a specified date in 2017. RN #100 further indicated that registered nursing staff are responsible to record on the Medication Administration Records (MAR) every shift when the resident is up in the wheelchair and that the seat belt restraint is properly applied as part of the reassessment of restraints every eight hours.

Inspector #547 obtained copies of the resident's MAR and observed that there was no documentation for the seat belt restraint monitoring and reassessment on ten specified day shifts and twenty three specified evening shifts of a specified month.

RN #100 indicated that when the MAR is not signed, it means that it was not done.

RN #109 further identified that the resident's care plan includes PSW documentation flow sheets, Medication Administration Records (MAR), and the resident's physical and electronic health care records. Inspector #547 reviewed resident #006's plan of care as identified by RN #109 and was not able to find any documentation regarding the person who applied the restraint device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. RN #100 indicated to Inspector #547 that they must have forgotten to add the monitoring forms in the home's flow sheet binders for this resident.

As such, resident #006's condition was not reassessed and the effectiveness of the restraining was not evaluated every 8 hours by a member of the registered staff and documented on the MAR. There was no documentation regarding the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

3. Resident #046 was admitted to the home in 2015 with several medical diagnoses.

Resident #046 was observed by inspector #547 to wear a seat belt when seated in a wheelchair on July 24, 25, 26, 27, and 28, 2017.

On July 26, 2017 RN #100 indicated that the resident wears a seat belt restraint when in

the wheelchair at all time for safety. RN #100 further indicated that registered nursing staff are responsible to record on the Medication Administration Records (MAR) every shift when the resident is up in the wheelchair, that the seat belt restraint is properly applied and the resident is reassessed every eight hours.

RN #133 indicated that the PSW's do not have access to the home's electronic documentation system and use the paper care plans and flow sheets located in binders at the nursing stations.

Inspector #547 obtained copies of the resident's MAR and observed that there was no documentation for any seat belt restraint identified on resident #046's MAR sheets for the month of July 2017. Inspector #547 reviewed resident #046's plan of care and flow sheets and observed there was no documentation for the seat belt restraint, the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

As such, the home's policy "Least Restraint" was not complied with for resident #046's use of a seat belt restraint.

4. Resident #047 was admitted to the home in 2009, with multiple medical diagnoses. The resident was observed by inspector #550 on August 2, 3 and 4, 2017 at various times during the day to have a seat belt with a sleeve cover in place when seated in the wheelchair.

On August 4, 2017, RN #102, PSW #140 and PSW #150 indicated to the inspector that resident #047 is to have a seat belt with a sleeve cover applied when seated in the wheelchair to prevent falls.

The inspector reviewed the resident's health care records on August 4, 2017. The "Prescribed Medical Guidelines" form for resident #047 contained a physician order for the seat belt restraint dated a specified date in 2016, renewed two months later and then one month later. It was documented on the MAR by the registered nursing staff for the months of June, July and August on days and evenings that the restraint was verified. There was no documentation whether the restraint had been used or not during the night shift. The inspector was not able to find any documentation regarding the application, the monitoring, repositioning of the resident, the discontinuance and the resident's

reaction to the use and application of the restraint prior to August 1, 2017.

Staff are to document on the restraint check form using this legend on the top of the form:

Key:
A - applied
V - visual observation
D - declined/refused (see progress notes)
P - in place
R - removed

Reaction:
0 - no reaction/calm
1 - agitated
2 - attempts to remove

On August 1, 2017, a "restraint check form" was initiated for resident #047 and noted the following:
-the prescribed restraint, the month and the year were left blank
-August 1: the restraint was applied at a specified time, there was a check mark hourly for a period of eight hours and in the column for the resident's reaction, and there was a "0" at the time the restraint was applied. No other documentation for that day.
-August 2: the restraint was applied at a specified time, and in the column for the resident's reaction, there was a "0" at the time the restraint was applied. No other documentation for that day.
-August 3: There was no documentation for that day.
There was no documentation regarding the repositioning of the resident and the post-restraining care.

On August 4, 2017, the Program Manager for Resident Care indicated to the inspector that the PSWs are required to document the application, the person who applied the restraint and the time, the monitoring, the discontinuance and the resident's reaction to the restraint on the "restraint check form" and that this form was implemented on August 1, 2017 after the revision of their restraint policy in January 2017. Before August 1, 2017, there was no documentation done except for the evaluation of the resident's condition and the effectiveness of the restraining done every eight hours by the registered nurses on the MAR. She indicated that the "restraint check form" has no

provision to allow the PSWs to document the repositioning of the resident and the post-restraining care. In reviewing the MAR and the "Prescribed Medical Guidelines" form with the inspector, she indicated that the registered staffs are to evaluate the resident's condition and the effectiveness of the restraining and document this in the MAR every eight hours; not just verify the restraint in the wheelchair as currently indicated on the MAR and that this is to be done every eight hours; not just on days and evenings. The physician has to review the restraint order at least quarterly.

As such, resident #047's condition was not reassessed and the effectiveness of the restraining was not evaluated every 8 hours by a member of the registered nursing staff and documented on the MAR. There was no documentation regarding the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. The physician did not review the restraint order quarterly as per their policy.

As evidenced above, the home's "Least Restraint" policy was not implemented for residents #003, #006, #046 and #047.

The scope and the severity of this non-compliance were reviewed. The fact that the home's restraint policy is not complied with is widespread and poses a risk for potential harm to all the residents who are being restrained. Non-compliance was previously issued as a voluntary plan of correction on March 8, 2017
. [s. 29. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #047.

On a specified date in 2017, a complaint was submitted to the Ministry of Health and Long Term Care and to the home by resident #047's family member. The complainant reported that the licensee was not following resident #047's plan of care regarding the use of a restraint to prevent falls. The complainant indicated that on a specific date in 2017 when he/she visited the resident at the home, he/she found resident #047 in the

hallway and the resident appeared to be sliding off the wheelchair and his/her bottom was at the edge of the seat. The complainant immediately noticed that the resident's seat belt was not applied and he/she requested the assistance of two staff members to help him/her find the seat belt.

The complainant is concerned that staff are not following resident #047's plan of care by not applying the seat belt when the resident is in the wheelchair which could potentially cause harm to the resident.

Resident #047 was admitted to the home in 2009, with multiple medical diagnosis. The resident is dependent of staff for mobility in the wheelchair.

Inspector #550 reviewed the home's internal investigation report regarding the complaint dated a specific date in 2017. It was determined that the PSW who cared for resident #047 on that specified date, had not reviewed the resident's plan of care prior to caring for the resident that day. Therefore the PSW was not aware that the resident required a seat belt restraint with a sleeve cover when seated in the wheelchair.

Inspector #550 observed resident #047 at various times on August 2, 3 and 4, 2017. At the time of the observations, the resident was observed to be seated in a wheelchair with a seat belt restraint and a sleeve cover applied.

On August 3, 2017, during an interview, RN #102 indicated to the inspector that resident #047 requires to have a seat belt in place at all times when seated in the wheelchair at the family's request to prevent falls. PSWs #141 and #150 indicated to the inspector that the resident requires to have a seat belt applied when seated in the wheelchair to prevent the resident from sliding off the wheelchair.

The inspector reviewed the resident's health care records. The written plan of care indicated under fall risk/use of psychotropic medication/restraint section (updated on a specified date), the following interventions:

• Ensure that the restraint is used as the last resort, i.e. all other options have been explored, such as entertaining activities, family support, less invasive treatments, and so on.
• Clearly indicate why, when, since when, and under what circumstances the resident is being restrained, what type of restraint is used, and who suggested the use of the restraint

• Use the least restrictive device if necessary, verify regularly that the device is applied properly and remains in place

Further reviewing the written plan of care, the inspector noted that under the Activities of Daily living/dental care section (updated on a specified date) the following interventions:

• Mobility: Fasten the seat belt when the resident is in the wheelchair, check that the resident does not detach the belt restraint, form signed / POA.

On August 3, 2017, during an interview, the Program Manager of Resident Care indicated to the inspector if an employee wants to know if a resident has a restraint and the directions for the application and use of the restraint, the employee would refer to the restraint section in the written plan of care. After reviewing resident #047's actual written plan of care with the inspector, the Program Manager of Resident Care indicated that the plan of care did not provide clear directions to staff. The information and interventions documented in the restraint and the activities of daily living sections regarding the use of a restraint are contradictory. The restraint section indicated that the use of a restraint is to be at the last resort and the activities of daily living section indicated the resident is to have a belt restraint when the resident is in the wheelchair and that staff are to ensure he/she does not release the restraint. The Resident Care Manager confirmed that the plan of care should indicate the use of a seat belt restraint with a sleeve cover at all times when the resident is in the wheelchair.

As evidenced above, the plan of care for resident #047 does not provide clear directions to staff and others who provide direct care to this resident. [s. 6. (1) (c)]

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

Review of the progress notes written by RPN #116 on a specified date indicated that resident #028 sustained a skin integrity issue to a specific body part while being transferred from the bed to the wheelchair. The skin issue was cleaned and a dressing was applied. Another note written by an identified nursing staff six days later indicated that she was informed by a PSW of resident #028's skin integrity issue. The RPN measured the skin issue, cleaned it and applied a dressing.

Review of the resident's Medication Administration Record (MAR) July 2017, indicated that the dressing for the skin integrity issue was performed on a specified date and the

square for staff initials was highlighted with a border for a specified date three days later and again seven days later but they were not initialed.

During an interview with RN #102 on August 2, 2017, she indicated that the squares for staff's initials were highlighted with a border for the specified dates to remind the staff to change the dressing. RN #102 stated that on both days, the above MAR did not indicate that the dressing was changed since there was no signature.

During an interview with RPN #116 on August 2, 2017, she indicated that the dressing was not changed on a specified date.

During an interview with RPN #149 on August 3, 2017, she indicated that the dressing was not changed on another specified date.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #028 as specified in the Wound Assessment Tool and on the above MAR sheet. [s. 6. (7)]

3. The licensee has failed to ensure that staff and others who provide direct care to residents are kept aware of the contents of the plan of care and have convenient and immediate access to it.

The home's process for availability of the plan of care for direct care nursing staff, is that the residents kardex, current care plans, documentation flow sheets, and hourly monitoring for restraints or positioning are printed on paper for manual documentation and reference. These are kept inside binders at the nursing stations at every resident care unit.

Resident #006 was admitted to the home in 2015 with several medical diagnoses including dementia. Resident #006 returned from hospitalization on a specific date with a request to place the resident in a wheelchair with a seat belt restraint. The resident's health care records indicated that a physician ordered the seat belt restraint on that same day. The resident's Substitute Decision Maker (SDM) consented for this seat belt restraint two days later. The resident's care plan was later updated in the home's electronic documentation system by RN #145 one hundred and one days later.

On August 2, 2017 RN #145 indicated to inspector #547 that she recalled nothing that resident #006's care plan did not indicate any use of a seat belt restraint and that she

added this information in home's electronic documentation system in the resident's most up to date care plan. RN #145 indicated that she did not print the updated care plan to replace the old care plan in the care plan binders used by direct care nursing staff.

The Program Manager of Resident Care indicated to inspector #547 on August 2, 2017 that PSW staff do not have access to the home's electronic documentation system, and would not have had convenient or immediate access to this restraint information as it was not printed or added to the floor's care plan binders/ monitoring sheets in the flow sheet binder.

As such, resident #006's updated plan of care was not made available to direct care nursing staff regarding the resident's abdominal seat belt restraint, interventions, and monitoring related to this restraint. [s. 6. (8)]

4. Resident #046 was admitted to the home on a specific date in 2015 with several medical diagnoses including behavioural issues. Resident #046 was assessed to require a seat belt restraint while in wheelchair for behaviour concerns. The resident's health care records indicated that a physician ordered the seat belt restraint on a specific date in 2017 as part of the three month review. The resident's Substitute Decision Maker (SDM) consented to this seat belt restraint on a specific date in 2016. The resident's care plan was later updated in the home's electronic documentation system by RN #145 eighteen days after the physician’s order regarding the use of a restraint for resident #046.

Inspector #547 reviewed the resident's actual care plan in the care plan binder and noted that the seat belt restraint was not in the resident's care plan.

On August 2, 2017 RN #145 indicated that she did not print resident #046's care plan when she updated it to replace the old care plan in the care plan binder, used by direct care nursing staff.

As such, the direct care nursing staff were not made aware of the contents of the plan of care and have convenient and immediate access to it for resident #046 restraint care needs. [s. 6. (8)]

5. The licensee failed to ensure that the following are documented:
1. The provision of the care set out in the plan of care.

During an interview with RN #125 on July 25, 2017, she indicated to inspector #550 that resident #025 was prescribed a specific drink as a supplement at meal time to increase body weight but the resident refuses to take them.

Inspector #550 reviewed the resident's health care records. Resident #025 was admitted to the home in 2005 with multiple diagnoses. The AIM assessment by the dietitian on a specified date in 2017 indicated that the resident's BMI was low, his/her weight was under normal weight range and that the resident had lost 9.4% of body weight in one month. That same day, the resident was prescribed a specific drink at each meals as a supplement.

On August 2, 2017, the Food Service Manager indicated to the inspector that because the specified drink cannot be sent with the resident when he/she goes out on a daily basis during the week, they send another type of drink every morning with the resident to take at lunchtime. Dietitian #146 indicated to the inspector that the drink sent with the resident is a comparable substitute for the specified drink at the home as the nutritional value in each are similar.

The inspector reviewed the documentation in the medication administration record (MAR) for two specified months in 2017. It was observed that for thirty three days in a row, the administration of the specified drink at each meal was not documented as follows:
0800 hours: 4 specified days;
1200 hours: 29 specified days;
1700 hours: 10 specified day.

RN #125 indicated that the resident is away during the day on weekdays and that he/she is given a specified drink to consume at lunchtime. She indicated she does not sign the specified drink at 1200 hours because the resident is not there on weekdays. On two specified week end days which this RN worked, she did not sign the administration of the specified drink at 1200 hours because she forgot.

On August 3, 2017, the inspector reviewed the documentation on the MAR with the Program Manager for Resident Care. She indicated to the inspector that staff are expected to document the administration of the specified drink on the MAR as it is a prescribed treatment. The days that the resident is away, because a comparable substitute drink is sent with the resident, the nurses are to document this as they would any other treatment when the resident is away. They have to document code 10 on the MAR to indicate that the resident is away with the medication/treatment. She explained

that no signature indicated that the treatment was not administered.

As evidenced above, the administration of the homemade milkshake which is prescribed as an intervention to promote weight gain for resident #025 was not documented. [s. 6. (9) 1.]

6. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change or care set out in the plan is no longer necessary. This inspection is related to Log #005084-17.

A critical incident report dated a specific date in 2017 and submitted the following day indicated that resident #009 had a fall on two specific dates in 2017. The resident was admitted to the hospital ten days after the last fall with a fracture.

Inspector #211 reviewed resident #009's health care record which indicated that the resident was admitted to the home in 2015 and diagnosed with Alzheimer's disease and another health condition.

The resident's written plan of care reviewed by inspector #211 on August 2, 2017, indicated that resident #009 was at risk for falls. The interventions indicated that the resident required a wheelchair for mobility and the wheelchair required to be pushed by a person.

The resident's nursing progress notes reviewed by Inspector #211 for sixty eight days in 2017, indicated that the resident was using a wheelchair for mobility after a fall on a specific date in 2017. However, during the above months, the resident was not following the instructions provided by the staff and often tried to walk without supervision. On a specific date in 2017, the nursing progress notes indicated that the resident was walking without assistance even though he/she was at high risk for falls due to an unstable gait.

On August 2, 2017, inspector #211 observed resident #009 sitting on a regular chair in the dining room, without any type of equipment.

During an interview with resident #009 on August 2, 2017, the resident indicated that he/she was walking independently without any equipment.

During an interview with RN #148 on August 3, 2017, indicated that the resident was

walking independently with supervision since approximately two months. RN #148 acknowledged that the interventions related to the resident's mobility were not updated when the written plan of care was revised.

During an interview with the Program Manager of Resident Care on August 3, 2017, indicated that when resident #009's mobility needs changed, the interventions in the resident's written plan of care should have been updated to reflect the resident's current needs.

As such, resident #009's plan of care was not reviewed and revised when the resident's mobility care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #047, the care set out in the plan of care is provided to the resident as specified in the plan, staff and others who provide direct care to resident #006 and #046, are kept aware of the contents of the plan of care and have convenient and immediate access to it, the provision of the care set out in the plan of care is documented for resident # 025 and resident #009 is reassessed and the plan of care reviewed and revised at least every six months and at any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s.8 (1)(b) 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 is complied with.

In accordance with LTCHA 2007, S.O., c.8, s. 21., the licensee is required to ensure that there are written procedures that comply with the regulations set out in O.Reg. 79/10, s.101. for initiating complaints to the licensee and for how the licensee deals with complaints.

The home's policy titled "Reporting Lost/Misplaced Items" #750.83, revised February 2016, indicated on page two of the procedure for resident's lost items that the unit staff will complete a search of the unit for the missing item and if it is not found, the unit staff will complete a lost item form #750.83 and forward this to the Manager of Hospitality. The Manager of Hospitality Services completes section two of the lost item form and its requirements. The Manager of Hospitality Services is then responsible to notify the family member of the results of the search, investigation and actions taken.

Resident #011's Power of Attorney (POA) had placed a quilt on the resident's bed that he/she said was labelled with the resident's name and room number. This quilt went missing over a month ago and the POA indicated to inspector #547 that he/she had reported this to the unit clerk and to the Manager of Laundry. The quilt was not found and he/she then purchased a second one exactly alike. The POA looked on each unit and was not able to find the missing quilt. The POA further indicated that he/she was not made aware by the Manager of Laundry of the results of their investigation for the

missing quilt.

On July 26, 2017 Inspector #547 interviewed PSW #110 caring for the resident on the unit, and she indicated that when they were made aware of a the missing item, they immediately did a search on the unit but the quilt was not found. They asked the POA to complete a lost item form that was provided to the Manager of Laundry.

Inspector #547 interviewed the Environmental Services Manager who indicated that there are gaps in their process for complaints about lost items. He recalled the lost item for resident #011, it had occurred over 10 days ago and was unsure as to where it was in the home's process. He indicated that he did not call their outside laundry company about this lost quilt. He indicated that he did not recall completing the section 2 of the lost item form, or provide a copy of the investigation and results to the home's Administrator. He further indicated that he had not notified the POA of the result of the search/investigation and actions taken regarding this complaint as required to date. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the policy, procedure from MediSystem pharmacy titled "Digital Mar/Tar and Electronic Medication Administration Systems", revised January 17, 2017 and put in place by the licensee is complied with.

In accordance with O.Reg.97/10 s.114(2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

This policy indicated the following for Digital Medication Administration Record (digiMAR) /Treatment Administration Record Sheets:

Every resident whose medications are administered by a nurse or care provider must have a Medication Administration Record (MAR) in accordance with legislation.

Checking new digiMAR sheets:
1. The pharmacy will provide printed digiMAR sheets every month.
3. The pharmacy will send the new digiMAR sheets 5-10 days prior to the start of the next month.
4. DigiMAR sheets will be printed with:
n) Special instructions (if applicable)

q) Directions for administration of medications (frequency)
6. Upon receipt of the new digiMAR sheets, two nurses of facility authorized care providers are to check all printed information for correctness, make appropriate corrections and inform pharmacy of any changes.
7. To ensure accuracy, each new sheet must be double checked against the Physician's Order Review, as well as the previous month's digiMAR sheets before being used. When checking the new digiMAR with the old digiMAR, a check mark or "x" can be placed in one of the three boxes provided in the left margin of the digiMAR.

On August 9, 2017 Inspector #547 reviewed the home's medication incident reports for the last quarter including April, May and June 2017. The Program Manager of Resident Care (PMRC) indicated to Inspector #547 that the home has had trouble with the review of the new MAR that arrive monthly. The PMRC further indicated that she also just found out from RN #125 that the registered nursing staff no longer reviewed the new MARs monthly with two registered nursing staff as required by this policy.

Medication incident reports for resident #007 and #054 reported on a specific date in 2017 identified that these residents did not receive a specific medication prescribed to be given four months earlier as due every six months and was last provided ten months ago. Upon review of the MAR, it was noted that when resident #007 and #054 were last provided the specified medication ten months earlier, that the registered nursing staff had not written on the MAR the special instructions of date the next dose was due and was left blank every month review for 10 months. These MAR's were also only revised for accuracy as required by one registered nursing staff as identified by the one signature at the bottom of each MAR sheet.

The PMRC indicated to Inspector #547 on August 11, 2017 that the MARs were signed by one registered nursing staff, which identified that they were not reviewed by two registered nursing staff as required by this policy. The PMRC indicated they will review this policy and procedure with all registered nursing staff in the home. [s. 8. (1) (b)]

3. According to O. Reg 79/10, s. 48. (1) Every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A fall prevention and management program to reduce the incidence of falls and the risk of injury.

The home’s policy #315.08 titled "Falls Prevention Program: Resident Assessment for

Falls Tool" dated September 2013, indicated that in the event of an un-witnessed fall, head injury will be assessed and neuro vitals will be taken. See AP&OP 315.11.

The home’s policy #315.11 titled "Assessment: Head Injury" dated September 2013, indicated that the head injury assessment and neuro-checks shall be completed on residents with actual or suspected head injury for a period of 72 hours from the time of the injury, using the appended neurological assessment tool.

This inspection is related to Log #005084-17, a critical incident report dated on a specified date in 2017 and submitted the following day indicating that resident #009 had a fall on two specific dates in 2017 and was admitted to the hospital with a specified injury ten days later.

Inspector #211 reviewed resident #009’s health care records which indicated that the resident was admitted to the home in 2015 and diagnosed with Alzheimer’s disease and another health condition.

Inspector #211 reviewed resident #009’s nursing progress notes for two specific dates. The nursing progress notes on the first date, indicated that an identified nurse heard a loud noise and found the resident lying on the floor beside the bed. The resident’s head was slightly elevated and the resident was unable to describe how he/she fell. The identified nurse indicated that the vital signs were taken. The nursing progress notes on the second specified date indicated that the staff found the resident sitting on the floor and hitting his/her feet on the bedroom door and that prior to the fall the resident was lying in bed. The vital signs were verified, to check the vital signs parameters and that the resident did not sustain an injury.

Inspector #211 reviewed the form titled "Resident Condition-24 hours Report" dated the day of the second fall which indicated the resident's blood pressure at a specific time.

Inspector #211 reviewed the Resident’s electronic documentation system under the task Vital Signs and Weights for a period of seven months in 2017 and observed that the vital signs were not documented on the two specified dates that the resident fell.

During interviews with RN #148 on August 3, 2017 and RN #136 on August 8, 2017, both indicated when a resident’ has an un-witnessed fall, they must initiate the head injury protocol.

During an interview with the Program Manager of Resident Care on August 8, 2017, she indicated that a head injury assessment should have been completed on both days the resident fell as the falls were un-witnessed. The vital signs parameters were not documented in the resident's electronic documentation system and the sheet titled "Neurological Flow sheet" was not completed for the above dates. The Program Manager of Resident Care indicated that the nurse did not follow both policies; Falls Prevention Program: Resident Assessment for Falls Tool and Assessment: Head injury.

As evidenced above, the policy #315.08 titled "Falls Prevention Program: Resident Assessment for Falls Tool" and policy #315.11 titled "Assessment: Head Injury" which is part of the home's fall program, were not implemented when residents #009 sustained un-witnessed falls with a possible head injury and the neurological assessment was not followed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policies regarding complaints, medication management system and fall prevention program are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

This home uses pagers as their communication and response system where the pager will alert the PSWs when a resident activates the call bell. By activating the call bell, this notifies PSWs via the pagers that this resident requires assistance.

During the resident observation on July 24, 2017 at 1420 hours, inspector #547 observed on the West wing of the second floor that PSW #129 had a pager that was not working. PSW confirmed to the inspector that sometimes the pagers do not work. She then replaced the pager in her pocket, and continued to make the bed in a resident's room.

On August 1st, 2017, inspector #550 observed on the second floor unit that three out of six PSWs had in their possession pagers that were not functioning.

PSW #111 had pager #501 in her possession and upon verification of functionality, it was observed that the pager was not working. The PSW indicated to the inspector that although she signed for the pager that morning, she did not verify it to see if it was working.

PSW #112 had pager #502 in her possession and upon verification of functionality, it was observed that the pager was not working properly. Although the pager's power was “on”, it did not display any calls when a call bell was activated. The PSW indicated to the inspector that she verified to make sure that it was “on” this morning but she did not know how to navigate these newer pagers for further verification.

PSW #121 had pager also labeled #502 in his possession and upon verification of functionality, it was observed that the pager was not working properly. Although the pager's power was “on”, it did not display any calls when a call bell was activated. The PSW indicated to the inspector that often the pagers on the unit are not working.

All three PSWs told inspector #550 that when the battery operated pagers are not working, they will change the batteries. If it is one of the newer pager that are not battery operated, they will inform the nurse.

RN #100 indicated to inspector #550 during an interview that when PSWs report to her that a pager is not working, she will inform the Program Manager of Personal Care or the Manager of Resident Care who will come and replace the pager with a functioning one.

During an interview on August 2, 2017 with the Program Manager for Resident Care, she indicated to inspector #550 that it is the home's expectation that when a PSW takes a pager at the beginning of a shift that he/she verifies it for functionality. The registered nurse is to report to her immediately when pagers are not functioning so she can replace them. She indicated she was not made aware by any staff as of that day that there were pagers on the second floor unit that were not functioning.

2. On July 24 and 25, 2017, inspector #547 and #550 observed that the varnish on the wood border around the counters in twelve residents' washroom was well worn, exposing a porous surface, which had not been maintained to provide for a surface that is able to be cleaned and sanitized.

It was also observed by both inspectors that on the second floor unit in the common area next to the nursing station, there were three gray and two burgundy leatherette chairs and two green fabric chairs. The varnish on all of these identified chairs was well worn and sticky, exposing a porous surface, which had not been maintained to provide for a surface that is able to be cleaned and sanitized. There were two leatherette lazy boy chairs; one green and one burgundy. The leatherette material on both chairs was ripped, exposing the padding of the chair.

On July 27, 2017, during an interview, the Maintenance Supervisor indicated to the inspector being aware of the well-worn vanish on the wood borders around counters in the residents' washrooms. He indicated that every time a room is vacant, the wood border is sanded and re-varnished as part of the maintenance of the room. Although being aware that this maintenance is required in all the residents' washroom, the Maintenance Supervisor indicated that he does not have the man power to do all the residents' washrooms at once.

During an interview, the Administrator indicated that when new furniture is required, the home's process is that staff report this to the registered staff and the registered staff are to inform the Administrator. She indicated not being aware of the state of condition of the chairs and residents' washroom counters. [s. 15. (2) (c)]

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 pager system, the wood border on the counters in the residents' washrooms and the chairs in the common area next to the second floor nursing station are kept in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In this report the resident-staff communication and response system is commonly referred to as the call bell system.

On July 24, and July 28, 2017, inspector #211 observed the call bell cord lying on the floor in resident #033's bathroom. The call bell cord was not accessible by the resident when seated on the toilet.

The resident's current written plan of care indicated that the resident was to be taken to the toilet every two hours.

During an interview with PSW #129 on July 28, 2017, the PSW indicated that the call bell cord was not accessible to the resident if seated on the toilet since the cord was lying on the floor. PSW #129 indicated that the cord should be attached to the right side support beside the toilet to be accessible to the resident. [s. 17. (1) (a)]

2. On July 24, 2017, inspector #547 observed the call bell cord wrapped several times around the towel rack far away from the toilet and out of reach from the resident if seated on the toilet in resident #009's bathroom.

On July 28, 2017, Inspector #211 observed the call bell cord wrapped several times around the towel rack far away from the toilet and out of reach from the resident if seated on the toilet in resident #009's bathroom.

Inspector #211 reviewed the resident #009's health care record indicating that the resident was admitted to the home in 2015 and diagnosed with Alzheimer's disease and another health condition.

Review of the resident's current written plan of care indicated that the resident needed encouragement and minor physical assistance to the toilet. The resident was at risk for falls and to ensure that call bell was accessible.

During an interview with PSW #130 on July 28, 2017, indicated that the resident walks independently and goes to the bathroom by himself/herself. PSW #130 indicated if the resident was unable to get up from the toilet, the call bell cord was not accessible to him/her since the cord was wrapped several times around the towel rack and the call bell system was too far to be reached. [s. 17. (1) (a)]

3. On July 24, 2017 at 14:36, inspector #550 observed resident #014's call bell cord in the resident's bedroom on the floor between the bed and the night table.

On July 31, 2017, inspector observed that the resident #014's call bell cord was wrapped and tied several times around the towel rack. During an interview with PSW #135, the PSW indicated that the resident was able to use the toilet, but she was informed by the regular staff that the call bell cord was wrapped around the towel rack because the resident was cognitively unable to use the call bell system. The inspector asked resident #014 if he/she was able to reach the call bell cord in the washroom. The resident demonstrated that he/she was unable to pull the call bell cord since the cord was wrapped and tied around the towel rack. PSW #135 then unwrapped the call bell from around the towel rack and the resident was able to use it.

On August 1, 2017 at 0852 hours, inspector #211 observed the call bell cord in resident #014's bedroom was on the floor behind the head board of the bed. On the same day at 1150 hours, inspector #211 observed the call bell cord hanging on the call bell system on the wall behind the resident's bed after housekeeping aide #143 cleaned the resident's bed. The call bell cord was not accessible for the resident. On August 2, 2017 at 0815 hours, inspector #211 observed that the resident's call bell cord was still hanging on the call bell system in the same position that it was placed by the housekeeping aide #143 on August 1, 2017.

Inspector #211 reviewed the resident #014's current written plan of care which indicated that the resident walked independently without equipment and required intermittent supervision and one person to assist in the toilet.

During interviews with housekeeping aide #142 and PSW #143 on August 2, 2017, they indicated that the call bell cord should always be attached the resident's bed for ensuring accessibility to the resident #014. [s. 17. (1) (a)]

4. On July 24, 2017, inspector #547 observed resident #006's call bell cord wrapped and tied around the towel rack and not accessible to the resident if seated on the toilet in the resident's bathroom.

On July 28, 2017, inspector #211 observed the above resident's call bell cord wrapped and tied around the towel rack and not accessible to the resident if seated on the toilet. Inspector #211 showed the above call bell cord to the Program Manager of Resident Care. The Program Manager of Resident Care unwrapped the call bell cord from the towel rack and stated that the cord should be placed on the toilet's armrest to be accessible for the resident.

Inspector #211 reviewed resident #006's current written plan of care which indicated that the resident required physical assistance in the bathroom and needed toileting before and after meals and at bedtime.

During an interview with the Program Manager of Resident Care on July 28, 2017, she indicated that resident #006 and every other residents in the home should not have the call bell cord wrapped around the towel rack placed far away from the toilet and the call bell cord in the residents' rooms should be attached to the resident's bed to ensure that it can easily be seen, used and accessible by residents, staff and visitors at all times.

The licensee has failed to ensure that resident #033, #009, #014 and #009's communication and response system was easily accessible for them, staff and visitors. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Licensee's policy and procedure titled "critical incident system-mandatory and critical incident reporting", #750.56, revised September 2016 was provided to Inspector #547 as the current policy in place at this time by the Program Manager of Resident Care on August 9, 2017. This policy stated for Mandatory reporting that any person that has reasonable grounds to suspect that abuse had occurred must immediately report the suspicion and the information upon which it is based to the Ministry of Health and Long-Term care (MOHLTC) by notifying the Administrator or Program Manager of Resident Care and having them submit a critical incident form and identify it as a mandatory report via the Critical Incident and reporting System (CIS). The After Hours Facility charge nurse will call the On-Call Manager who will call the after hours number for the MOHLTC and the number was provided.

A critical incident was submitted to the Director on a specific date in 2017 reporting an incident of alleged sexual abuse of resident #012 that occurred two days earlier.

The Program Manager of Resident Care(PMRC) indicated to inspector #547 to have been the On-Call Manager on the day the incident occurred and that the evening Charge RN #153 had tried to reach her to report this incident but could not reach her. RN #153 indicated to inspector #547 that because she could not reach the On-Call Manager (PMRC) in the home, she called the On-Call Manager for a sister home to report the incident. The On-Call manager of the sister home then reached the home's On-Call Manager via telephone and in turn, informed her of the incident. When the PMRC arrived on-site, RN #153 informed her that she had notified the police and the Director of the critical incident. The PMRC was not aware that RN #153 notified the Director via email instead of calling the after hours pager as per the home's procedure. She indicated to inspector #547 that she should have clarified with RN #153 how she notified the Director to ensure the reporting was done as per the home's procedure; calling the after hours pager.

As such, the Administrator was informed by the Centralized Intake, Assessment and Triage team with the MOHLTC on a specific date that email reporting was not an acceptable reporting method to the Director. The Director was informed via the Critical Incident reporting system as required by this policy two days after the incident occurred. [s. 20. (1)]

2. 2. Physical abuse is defined by the LTCH, 2007, O.Reg 79/10, s.2 (1) (a), the use of physical force by anyone other than a resident that causes physical injury or pain.

The home's policy #750-65 titled "Abuse" dated February 2017, indicated that the home is committed to zero tolerance of abuse or neglect to the residents and that the home has the duty to report any alleged harm, abuse or neglect done to a resident. There are two different ways to report abuse or neglect:

1. Internally by telling a charge nurse or manager, as appropriate
2. Directly to the MOHLTC
-By calling Long-Term Care Action line 1-866-434-0144 (7 days a week, 08:30 am to 7:00 pm)
-By sending a written letter by mail to Director, Performance Improvement and Compliance
Branch, Ministry of Health and Long-Term Care, 1075 Bay Street, 11th floor, Toronto, On M5S 2B1

Procedure:
1. Report immediately any suspicion or allegation of resident abuse to the Charge Nurse.
2. The Charge Nurse will immediately examine the resident. If the allegation is one of physical abuse, take pictures of the affected area and determine whether a physician need to be called.
3. Document results of examination.
4. Immediately report the allegation to the Administrator and Manager of Resident Care.
5. Have the staff member reporting or making the allegation immediately write a report of what they saw or heard.
6. The Program Manager, Resident Care or delegate will immediately notify the resident's substitute decision maker if the alleged, suspected or witnessed incident resulted in physical injury, pain or distress to the resident that could potentially be detrimental to the resident's health or well-being.
Otherwise notify the resident??s substitute decision maker within 12 hours of any other incident of abuse or neglect.
7. The Administrator or delegate must immediately notify
• The Ottawa Police if it is believed that the incident constitutes a criminal offense.
• The Ministry of Health and Long Term Care (refer to decision tree)
8. Manager of Resident Care or designate will complete a Critical Incident report. (please refer to P&P 750.56-Critical Incident System-Mandatory and Critical Incident Reporting).

This inspection is related to Log #012455-17, a critical incident report dated a specific date in 2017 and submitted two days later, indicating that resident #052 reported that a woman squeezed a specific body part because the resident had soiled the bed and told

the resident that he/she should have used the call bell system.

Inspector #211 reviewed the resident #052's health care records which indicated that the resident was admitted to the home in 2017, and diagnosed with a specific bladder condition and other health conditions. The progress notes for two specific dates described the sequence of the event as follows:

-On a specific date and time, RN #125 documented that resident #052 reported to different staff that a woman squeezed a specific body part because he/she wet the bed. Furthermore, the resident indicated that the woman told the resident that he/she should have used the call bell system to request staff assistance.
-At a specific time, the progress note indicated that the resident sustained an injury to a specified body part.
-On the same day at a specific time, an e-mail was sent from RN #125 to the Program Manager of Resident Care indicating that resident #052 reported a woman had squeezed a specific body part and he/she did not remember if the incident happened during the evening or the night on the specific date. The email indicated that according to the resident, the woman was upset because he/she wet the bed and she told the resident that the next time he/she should use the call bell for assistance to the toilet.
-On a specific date and time, the nursing progress notes written by RN #153 indicated that a follow-up related to the resident's injury was pursued with the PSW #155 who worked with RPN #152 the shift the incident occurred. The PSW #155 indicated that the resident screamed when RPN #152 touched the specified body part but he did not hear the conversation.
-Two days later, the nursing progress notes written by the Program Manager of resident Care indicated that the resident's substitute decision maker (SDM) was informed and the police was contacted related to the injury to the resident that occurred during the week-end.

During an interview with RN #125 on August 9, 2017, she indicated that resident #052 reported in the morning on a specific date that a staff squeezed a specified body part and the resident did not remember if the incident happened during the evening or the night on the specified date. RN #125 indicated that the incident was possibly an alleged abuse and she did not contact the manager on call to report the incident. RN #125 indicated that she sent an e-mail to the Program Manager of Resident Care (PMRC) the day it was reported and does not know what actions were taken afterwards by the PMRC.

During an interview with RPN #152 on August 8, 2017, she indicated that resident #052's

clothes and bed sheets were changed with two staff assistance on a specific date and time. RPN #152 indicated that she grabbed the resident under a specified body part with her elbow and pulled the resident forward to remove a piece of clothing. RPN #152 stated that the resident screamed when she was holding the specified body part and the resident confirmed that he/she had pain. RPN #152 indicated that she did not observed an injury on the resident's specified body part. RPN #152 stated that the resident did not express concern with the care and she did not realize that the specified body part was an issue at that time.

During an interview with PSW #155 on August 10, 2017, he indicated that he only heard the resident complaining of pain when he was helping the resident to turn on his/her side with the assistance of RPN #152. PSW #155 indicated that the resident was pleased after the care was provided and the resident did not indicated that the care was not provide properly.

During an interview with the Program Manager of Resident Care on August 8 and 10, 2017, she indicated that the nurse did not follow the policy indicating that any person that has reasonable ground to suspect that abuse had occurred must immediately report the suspicion and the information upon which it is based to the Ministry of Health and Long-Term care (MOHLTC) by notifying the On-Call Manager after facility hours. The Program Manager of Resident Care stated that the MOHLTC and the police force were contacted two days later when she noticed the incident report. The Program Manager of Resident Care indicated that RN #125 should have informed immediately the nurse in charge responsible of the home to ensure that the manager on call was contacted immediately related to the alleged abuse.

The Program Manager of Resident Care indicated that the investigation of the incident and contacting the MOHLTC and the police should have been started immediately on the day the resident reported the incident.

As such, the home's written policy regarding zero tolerance of abuse and neglect to resident #052 was not complied with. [s. 20. (1)]

3. This inspection is related to Log #017586-17, critical incident report dated on a specified date and time in 2017 and submitted to the Director two days later. The above Critical Incident Report (CIS) indicated that resident #053 was found having sexual behaviours in the presence of resident #056 without physical contact in an identified resident's bathroom on a specified date and time. Both residents were separated and

resident #056 stated that he/she did not remember the incident and did not demonstrate anxiety or change of behaviours.

Inspector #211 reviewed the resident #053's health care record which indicated that the resident was admitted to the home in 2017 and diagnosed with dementia and other health conditions. The nursing progress notes reviewed by inspector #211, indicated that the resident had already demonstrated sexual behaviours toward resident #012 on the day following his/her admission at a specified time. It was also documented that an incident of alleged non-consensual sexual behaviour had occurred twelve days later and another two days after the second incident.

Second incident:
On a specific date and time in 2017, the nursing progress notes written by RPN #108 indicated that the staff reported that resident #053 had kissed resident #058 on the lips. It also indicated that the evening staff were informed to do a follow-up. On the same day approximately 1.75hrs later, the nursing progress notes written by RN #109 indicated that the psychogeriatric nurse was informed of the said incident between resident #053 and #058 and both residents did not remember the incident.

During an interview with PSW #110 on August 14, 2017, she indicated that she saw resident #053 kissing resident #058 and she immediately informed the nurse. During an interview with RN #109 on August 14, 2017, she indicated that PSW #110 and PSW #112 reported that resident #053 kissed resident #058 on a specific date and time. RN #109 indicated that she was not aware where, when and how the incident happened and she did not inform the management staff of this incident.

During an interview with the Program Manager of Resident Care on August 14, 2017, she indicated that she was informed on August 11, 2017, of the alleged incident of non-consensual sexual behaviour between resident #053 and resident #058 that occurred on this specific date. The Program Manager of Resident Care indicated that RN #109 should have immediately informed management of the incident and that the home's policies were not followed for this incident of alleged sexual abuse.

Third incident:
On a specific date and time, the nursing progress notes written by RN #145 indicated that resident #053 was found with resident #056 in an identified resident's bathroom. Resident #053 was demonstrating sexual behaviours in the presence of resident #056 without touching the resident. The residents were separated and the staff was reminded

not to leave resident #053 with specified residents.

During an interview with RPN #140 on August 14, 2017, he indicated that PSW #154 was assigned to be the 1:1 staff to supervise resident #053 on the day of the incident during the evening shift. RPN #140 indicated that he was informed by PSW #161 that residents #053 and #056 were in an identified resident's bathroom. RPN #104 indicated that resident #053 was found sitting on the toilet with his/her bottom clothing pulled down exhibiting a sexual behaviour while inviting resident #056 to come closer who was standing at the bathroom door. RPN #140 indicated that resident #056 was trying to get out of the bathroom area and he/she did not demonstrate any reaction. RPN #140 indicated that when resident #053 suspected that someone was behind the bathroom's door, the resident stopped the sexual behaviour. RPN #140 indicated that the residents were separated and he informed RN #145 immediately.

During an interview with PSW #154 on August 15, 2017, she indicated leaving resident #053 unsupervised to take a 9 minute break and when she returned on the unit after her break, she was informed by RN #145 that there was a non-consensual behaviour of sexual nature between resident #053 and resident #056. Furthermore, PSW #154 indicated that she had heard during the shift report prior to that day, that resident #053 did not need constant 1:1 staff supervision.

During an interview with RN #145 on August 15, 2017, she indicated that she did not contact the manager on call related to resident's alleged sexual behaviour and that mandatory reporting policies were not followed.

During an interview with the Administrator on August 15, 2017, she indicated that RN #145 should have contacted the On-Call manager immediately related to resident #053's alleged sexual incident toward resident #056 as per the home's policy. The Administrator indicated that when she returned to the home the following Monday, she realized that the Director and the police were not notified of the alleged incident. The Administrator indicated that she immediately notified the police and completed and sent the Critical Incident Report to the Ministry of Health and Long-Term Care (MOHLTC) two days after the incident occurred.

The licensee has failed to ensure that the home's Abuse policy was complied with related to resident #053's alleged sexual behaviour toward resident #058 on a specific date and to resident #056 on another specified date two days later. [s. 20. (1)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident.

This inspection is related to log #015638-17.

A critical incident report was submitted to the Director on a specific date in 2017 reporting an incident of resident to resident sexual abuse that occurred two days earlier. It was reported that on a specific date and time in 2017 when PSW #154 was doing her round, she observed that resident #053 was in resident #012's room. Resident #012 was in bed and resident #053 had his/her mouth over a specific body part on resident #012's body. Resident #053 was naked from the waist down.

Resident #053 was admitted to the home in 2017 with several medical diagnoses including vascular dementia.

On August 10, 2017, inspector #547 interviewed RN #133 regarding resident #053's 24 hour plan of care, that was developed based on admission assessment documents and the first 24 hour observations of the resident as she had completed the resident's admission to the home. RN #133 indicated that the 24 hour plan of care is to be updated by the registered nursing staff in the home until the Minimum Data Set (MDS) coordinator is able to complete the initial plan of care. Upon review of the 24 hour plan of care paper copy, inspector observed that there was no information regarding the resident's inappropriate sexual behaviour that occurred on a specific date in 2017 the day after the resident's admission. RN #133 indicated that they had not been informed of any inappropriate sexual behaviour prior to the admission for this resident. The resident's electronic plan of care was first initiated three days after the admission date in 2017 regarding the resident's inappropriate sexual behaviour.

RPN #156 reviewed the binders at the nursing station and observed that resident #053 did not have any care plan accessible to direct care staff printed after the resident's admission. RPN #156 indicated that the home's electronic documentation system which had the most up to date care plan for the resident was not accessible to staff and did not give clear direction to staff related to the resident's sexual behaviours. [s. 24. (3) (b)]

2. The licensee has failed to ensure that resident #053 was reassessed and the 24-hour admission care plan was reviewed and revised when the resident's care needs change.

This inspection is related to log #015638-17.

RPN # 140 indicated to inspector #547 that on a specific date in 2017, resident #053 was very agitated at supper time, as the resident was looking for his/her house keys. RPN #140 provided a specific medication at a specific time with no effect as the resident continued to look for his/her house keys. PSW #154 indicated that approximately 1.5hrs later, she observed that resident #053 was on the side of resident #012's bed near the window and was not wearing any clothing on his/her lower body. Resident #012 was lying in bed and resident #053 was bent over the resident with his/her mouth on resident #012's specific body part. Resident #012 had no reaction. When PSW #154 stopped resident #053 from this action, the resident became very agitated and put his/her clothes back on. Resident #053 asked if the police would be contacted and PSW #154 responded that they would be. While waiting for the RN to come to the resident's room,

resident #053 told PSW #154 that if resident #012 did not want to continue, the PSW could take the resident's place if she wanted.

RN #153 indicated to inspector #547 that after the incident, she immediately initiated 1:1 surveillance for resident #053.

Resident #053's care plan was not updated with this reassessment of the resident's care needs after this incident occurred. [s. 24. (9) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 24-hour admission care plan sets out clear directions to staff and others who provide direct care to the resident and that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The LTCHA defines a PASD as a personal assistance service device, being a device used to assist a person with a routine activity of daily living.

Resident #025 was admitted to the home in 2005 with several health condition.

During observation of the resident on July 25 and 27, 2017, inspector #550 observed the resident sitting in a wheelchair with a front closure seat belt applied. The resident was cognitively not able to remove the seat belt when asked and prompted by the inspector.

On July 27, 2017, RPN #122 and PSW #123 both indicated to the inspector that the seat belt is applied as a positioning device as the resident often sits with his/her legs crossed on the seat of the wheelchair and leans forward. They indicated the resident would not be able to get up on his/her own if the belt was not applied. RN #125 indicated the resident is not cognitively able to remove the seat belt on his/her own.

Inspector reviewed the documentation in the health care records for resident #025 and was not able to find any documentation regarding the seat belt. The Program Manager of Resident Care indicated to the inspector that the seat belt is supposed to be documented in the resident's plan of care and that she was going to ask the unit clerk to verify the thinned chart for any documentation. The Unit clerk #128 indicated to the inspector she was not able to find any documentation regarding the seat belt in the resident's thinned chart.

As evidenced above, the PASD used to assist resident #025 with positioning, was not included in the plan of care. [s. 33. (3)]

2. Resident #003 was admitted to the home in 2015 with several medical diagnoses including Psychiatric Symptoms of Dementia (BPSD).

Resident #003 was observed on July 24-25-26-27-28 and 31, 2017, to be seated in a tilt position at different angles when in his/her wheelchair.

PSW #112 indicated to inspector #547 on August 1, 2017, that resident #003 is placed in a tilt position after meals for comfort, and that they reposition the resident's tilt at different angles throughout the day.

Inspector #547 reviewed resident #003's plan of care and noted that there was no information related to the use of the tilted wheelchair as a PASD for activities of daily living.

On July 31, 2017, the Program Manager of Resident Care indicated to Inspector #547

that resident #003's PASD of tilt action and requirements was not identified in the plan of care as required. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the PASD used to assist resident #025 and #003 with a routine of activity of living is included in their plan of care, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #057 receive end-of-life care in a manner that met the resident's needs.

This inspection is related to Log #017157-17.

On a specified date in June 2017, a complaint was submitted to the home's Administrator by resident #057's family members reporting their dissatisfaction regarding the end of life care the resident received at the home. The resident's family member reported that on a specified date and time in 2017 the resident's breathing became strenuous and that secretions were present in his/her throat. They called the nurse to the room who informed them that she was going to do her round and come back later. By the time the nurse returned approximately 1.25h hour later, the resident had respiratory difficulties due to the secretions in his/her throat. The nurse attempted to remove the secretions with tissue paper and then went to get the suctioning machine. When she returned, the nurse indicated there was no tubing for the suction machine and proceeded to remove the secretions with a specific equipment and tissue paper. The nurse then informed them that the resident was dying, the resident's color changed to grey and the resident passed away.

Inspector #550 reviewed resident 057's health care records. Resident #057 was admitted to the home in 2012 with multiple diagnoses. On a specified date in the spring in 2017, the resident was placed on palliative care by the physician after a discussion with the family members.

On August 14, 2017, at 1520hrs, inspector #550 interviewed RN #160 who was the RN caring for resident #057 on the specified date and time. RN #160 indicated to the inspector that during the shift in question at a specified time, she went into the resident's room after the resident's family member had rang the call bell. Upon entering the resident's room, she could hear that the resident was having pulmonary congestion but it was too early to administer a specific medication to alleviate the resident's symptoms. RN #160 indicated that she did not look into the resident's mouth to see if there were secretions present as she could hear that the congestion was in the resident's lungs and not in the throat. She then went to do a round and returned approximately one hour later. At that time, she was about to administered medications to the resident and noticed the resident had a fair amount of thick yellow secretions in the mouth. She positioned the resident on the side and attempted to remove the secretions with tissue paper. She left the resident with the PSW, went to get the suction machine and called RN #162 who was the RN in charge for assistance. When she got the suction machine, she noticed that there was no tubing and no suctioning tip available to allow her to suction the resident. When RN # 162 arrived at the resident's bedside, RN #160 asked her to go find tubing and a suction tip on the other floors. In the meantime RN #160 with the assistance of the PSW was trying to remove the secretions from the resident's mouth with a specific piece of equipment. RN #162 called RN #160 and informed her she was not able to find any tubing or suction tip for the suction machine. RN #160 kept on cleaning the secretions and indicated that the resident appeared to be in distress. At this point, the resident turned gray, threw up a large amount of secretions with rust colored emesis, stopped breathing and then passed away. RN #160 indicated that she was very upset that there was no functioning suction machine available for her to use in attempt to clear the secretions in resident #057's mouth. Because of this, she indicated she felt she was not able to care properly for the resident when the resident was dying.

During an interview, the Program Manager for Resident Care indicated that she was made aware of this incident by RN #160 as the suction machine was not functional due to the missing equipment and that she had not been able to provide the proper care to resident #057. The internal investigation conducted by the Program Manager for Resident Care revealed that there was tubing and suction tips available on the 2nd and

3rd floor and that RN # 162 had not gone to these floors in her search, she only went to the 4th floor. There was no tubing or suction tip on the 4th and 5th floor and no one had informed her of this so she could re-order more. After this incident, the PMRC put a protocol in place to ensure that there is always tubing and suction tips available on all units at all times and she also has kept a stock in the basement for emergency situations. Due to a lack of supplies (tubing and suction tip), resident #057 did not receive the proper end-of-life care as RN #160 was not able to use the suction machine to properly clear the secretions in the resident's mouth. [s. 42.]

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 resident receive end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On July 24, 2017, inspector #211 observed a scab to a specific body part on resident #028.

On July 31, 2017, inspector #211 and RN #102 observed that the scab on the resident's specific body part was partially removed leaving a pinkish scar.

Review of the progress notes written by RPN #116 on a specific date in 2017, indicated that resident #014 sustained a skin injury to a specified body part during a transfer. The skin injury was cleaned with normal saline and a dressing was applied.

Review of the nursing progress notes by RN #163 six days after the initial progress note, indicated that resident #028 had sustained a skin injury on a specified body part. The nursing’s progress notes indicated the dimensions of the skin injury and that it was cleaned and a dressing was applied.

Review of the form # 355.29B titled "Wound Assessment Tool" completed on that same day, indicated to clean the skin injury of the specified body part with normal saline and to apply a specific type of dressing eery three days.

During interviews with RN #102 and RPN #116 on August 2, 2017, they indicated that the Wound Assessment Tool was not completed on the day the staff discovered the skin injury. Furthermore, RN #102 indicated that the Wound Assessment Tool was not completed at least weekly by a member of the registered nursing staff after the initial assessment was completed.

During an interview with the Program Manager of Resident Care on August 1, 2017, she indicated that the Wound Assessment Tool should have been completed on the day the injury was reported. In addition, the skin injury should have been reassessed weekly by a member of the registered nursing staff after the initial Wound Assessment tool was completed.

The licensee has failed to ensure that resident #028 who was exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff, using a

clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #11: 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 are taken to minimize the risk of altercations and potentially harmful interactions between and among resident, including identifying and implementing intervention.

This inspection is related to Log #017586-17, Critical Incident Report dated on a specified date in 2017, that was submitted to the Director two days later. The above Critical Incident Report (CIS) indicated that resident #053 was found having a sexual behaviours in the presence of resident #056 without physical contact between the residents in a specified bathroom on a specified date and time in 2017. It indicated that

both residents were separated and resident #056 stated that he/she did not remember the incident and the resident did not demonstrate anxiety or change of behaviours after the incident.

Inspector #211 reviewed the resident #053's health care record which indicated that the resident was admitted to the home in 2017 and diagnosed with dementia and other health conditions. The nursing progress notes reviewed by inspector #211, indicated that the resident had already demonstrated sexual behaviours toward a female resident the day following his/her admission and twelve days after the first incident. Two days after the second incident the nursing progress notes written by RN #145 indicated that resident #053 was found with resident #056 in an identified resident's bathroom. The notes indicated that resident #053 was found sitting on the toilet, exhibiting a sexual behaviour in the presence of resident #056 without touching the resident. The residents were separated and the staff was reminded not to leave resident #053 with specified residents.

During an interview with RPN #140 on August 14, 2017, the RPN indicated that PSW #154 was assigned to do 1:1 supervision for the evening shift for resident #053 the day of the third incident. RPN #140 indicated that he was informed by PSW #161 that residents #053 and #056 were found in a resident's bathroom. Resident #053 was found sitting on the toilet exhibiting a sexual behaviour while inviting resident #056 to come closer. RPN #140 indicated that resident #056 was trying to get out of the bathroom and did not demonstrate any reaction to the other resident's behaviours. RPN #140 indicated that when resident #053 suspected the staff was behind the bathroom door, the resident stopped the sexual behaviour. RPN #140 indicated he informed RN #145 immediately. RPN #140 indicated that PSW #154 who was assigned to perform the 1:1 supervision of resident #053 was not present when both residents were found in the specified room.

During an interview with PSW #154 on August 15, 2017, she indicated leaving the resident #053 unsupervised to take a break and when she returned on the unit after her break, she was informed by RN #145 of the incident. PSW #154 indicated that she had been informed during a shift report prior to the third incident that resident #053 no longer needed constant 1:1 staff supervision.

During an interview with RN #145 on August 15, 2017, the RN indicated that PSW #154 was assigned to do 1:1 supervision for resident #053 on the date of the third incident during the evening shift and that after the incident, she reminded PSW #154 to inform another staff to supervise resident #053 when she leaves for her break.

During an interview with the Administrator on August 14, 2017, she indicated that their internal investigation of the incident revealed that PSW #154 had left for her break and did not inform anyone to take over the 1:1 supervision for resident #053. Furthermore, the Administrator indicated that PSW #154 revealed it was not clear to PSW #154 if she was assigned to perform 1:1 supervision for resident #053. The Administrator indicated that resident #053 should have received the following supervision:
• A 1:1 staff supervision 24 hours a day on four specified days,
• A 1:1 staff supervision for the evening and night shifts the following twenty-one days,
• A 1:1 staff supervision 24 hours a day from the twenty second day on.

During an interview with the Program Manager of Resident Care and the Administrator on August 15, 2016, they indicated that resident #053's written plan of care for a specified period of time did not indicate the 1:1 staff supervision requirement. The Program Manager of Resident Care indicated that since the resident's written plan of care was updated on a specified date, the 1:1 staff supervision 24 hours per day intervention was clearly identified. This intervention was still required and it is still in place. The Administrator indicated that the home's daily assignment sheet titled "Tele-staff" and the daily assignment for the second floor unit did not always indicate clearly who was assigned to provide the 1:1 supervision to resident #056 during the evening shift for a specified month except for two specific dates in that month. Furthermore, she indicated that the review of the daily assignment sheet for a specified date and discussion with staff, revealed that there was no staff assigned to provide the 1:1supervision to resident #053 on a specific date during the evening shift.

As such, steps were not taken to minimize the risk of altercations and potentially harmful interactions between resident #053 and other residents, as the 1:1 supervision was not implemented. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing intervention, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snacks.

Inspector #547 reviewed the planned menu cycle for weeks one, two and three of a four week cycle for residents in the home. This menu did not specify therapeutic or texture modified diet needs for meals or snacks. Dining observations were conducted over the course of this inspection and it was observed that food is prepared for meals as per the planned menus in resident required therapeutic or texture modified for their care needs from the regular planned menu items and no alternatives required.

On July 27, 2017 Dietary aide #114 indicated to Inspector #547 that food is prepared according to the planned menu from the main kitchen and they refer to the dietary plan of care for residents on the floors regarding the therapeutic or texture modified needs for meals. Dietary aide #114 further indicated that all residents are offered the same menu items as identified on the main menus.

On July 31, 2017 PSW #151 distributing the afternoon snack to residents on the fourth

floor indicated to Inspector #547 that the dietary aides prepare the snack trolley with an assortment of juices, water, texture adjusted beverages and usually a plate containing the snack option for the afternoon. PSW #151 further indicated that there is usually other snack items to offer residents from the kitchen if residents request it, but they start with what is provided by the kitchen as per the daily snack schedule. PSW #151 indicated that there was no therapeutic or texture modified option for snacks provided by the kitchen as per the daily snack menu, therefore snacks are only offered to residents on regular texture diets.

On July 31, 2017 PSW #113 indicated that they provide snacks to residents on regular texture diets unless the snack sent by the kitchen is in a consistency permitted to be consumed by residents on modified texture diets. Staff can get apple sauce or yogurt from the unit kitchen for others when these are available. PSW #113 indicated to Inspector #547 that the regular texture snack item is not altered for residents requiring texture modified diets.

On August 2, 2017 the home's dietitian was on vacation and dietitian #146 who was covering for her indicated upon review of the home's planned weekly menu cycle, that there was no option that day for therapeutic or texture modified diets as the regular item was raspberry tart that cannot be adjusted for minced or pureed dietary needs.

On August 2, 2017 Inspector #547 interviewed the Food Services Manager (FSM) who indicated that the cook prepares all the meals and snacks in the home including meals for residents requiring therapeutic or texture modified diets. All the food is prepared on site at the home. Cook #144 indicated to Inspector #547 that she prepares texture modified food for every meal but that she was never requested to do the same for the snack options from the menu and has always provided the snack items to the floors in regular texture. The Food Services Manager indicated that they would review the menu for snacks to ensure that there is therapeutic and texture modified items available as per the planned menu and if they cannot modify the item, they will have to identify this on the menus.

Fifteen of the thirty nine residents on the second floor unit and sixteen of the forty residents on the fourth floor unit require therapeutic or texture modified items for snacks and the modified texture and therapeutic snacks were not provided to these residents as required. [s. 71. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's cycle menu includes menus for therapeutic and textured diets for snacks, to be implemented voluntarily.

WN #13: 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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes communication of the seven-day and daily menus to residents.

The following observations were observed regarding the daily and seven-day menus for the second and fourth floors:

On Friday July 21, 2017 inspector #547 observed that the daily menu indicated week one - Thursday lunch menu. The seven-day menu indicated menu items for week four. Inspector #547 was informed by dietary aide #118 that they were currently in week one in the home's menu cycle. Inspector #547 observed the daily and seven-day menus on the second floor daily beginning July 24, 2017 to not have been changed and continued to indicated daily menus as week one and seven-day menu as week four.

On Wednesday July 26, 2017 inspector #547 observed the fourth floor daily menu to indicate week one and the seven-day menu also indicated week one, however the dietary aide indicated that it was week two.

On July 28, 2017 inspector #547 interviewed dietary aide #118 on the second floor who indicated that the menus are changed by the nutrition supervisors daily. Inspector #547 interviewed the nutrition supervisor #120 who indicated that the daily menus are to be updated in the morning for the breakfast and lunch meals by the dietary aides on the units, and the supper menu is changed by the dietary aide doing the supper meal to reflect the current menu of the day. The weekly menus are to be changed weekly on Saturday nights by the nutrition supervisor to reflect the new week after the last meal on Saturday evenings. The Food Services Manager (FSM) indicated that he went to every floor, and corrected each seven day menu to reflect the current menus for the week, and will ask the supervisor to ensure that the daily menus are available on each floor and posted, and that the dietary aides are aware to ensure that the daily menu items posted are what is being provided to the residents daily. [s. 73. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the daily menu is communicated to the residents, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #547 reviewed the home's medication incident reports for the last quarter (April, May and June 2017) and identified the following:

On a specified date, the residents Medication Administration Record (MAR) identified that resident #055 was administered a specified medication as required for pain by the RPN at a specified time. Resident #055 was administered another dosage of the same specified medication 90 minutes after the initial dose which was ordered to be administered at a specific time as the regular prescribed dose by the RN #100. When RN #100 documented this administration on the narcotic count documentation form, she noted that the RPN from the previous shift had already administered the scheduled dose 90 minutes earlier than the scheduled time. As a result, the resident had received a double dose of the scheduled medication plus another dose as a PRN of the specified medication within a 90 minute period. The physician's order indicated the specified medication at a specified dosage to be administered p.o. twice daily plus the same specified medication at a lower dosage p.o. every four hours as required for pain. The specified medication was not provided to resident #055 in accordance with the directions for use specified by the prescriber.

On a specified date resident #007 and #054 were noted to not have received a specific injectable medication for the treatment of a specific medical condition that were due four months earlier. These drugs were to be administered every six months to these residents in accordance for use by the prescriber that was last provided to these resident 10 months earlier. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving residents #007 and #054 was reported to the resident, the resident's SDM if any.

Inspector #547 reviewed the home's medication incidents and adverse drug reactions for the last quarter for April, May and June 2017. The following was observed:

Medication incident report for resident #007 and another one for resident #054 dated on a specified date identified that these residents had not received a specified injectable medication as prescribed every six months for a specified medical condition. Incident report identified that both resident #007 and #054 had last received the specified medication in a specified on a specified date and were both due on another specified date six months later. This incident was discovered four months after the medication was due to be administered, and provided to the residents the day after the error was discovered.

The Program Manager of Resident Care (PMRC) indicated to inspector #547 on August 9, 2017 that upon review of the resident's medication incident reports and health records, that the residents SDM's were not informed of these medication incidents as required by this section. [s. 135. (1)]

2. The Licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions are reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b)

Inspector #547 reviewed the medication incidents and adverse drug reactions in the home for the last quarter. Over the course of this quarter, medication incidents were documented manually for a specified month in 2017 and then electronically for the two following months. These medication incident reports are provided to the Program Manager of Resident Care (PMRC) for review.

On August 9, 2017 the PMRC indicated to Inspector #547 that she was provided the original manual incident reports in a specific month in 2017 for resident #055 regarding a medication incident of receiving a double dose of a specified medication in error by RN #100. The PMRC indicated that she received the incident report, but had not had a chance to review or analyze this incident yet or take corrective actions.

On August 9, 2017 the PMRC printed the electronic medication incidents reported to her through the home's pharmacy MIRS- a new electronic medication incident reporting system program as per the new process for two other specific months in 2017. The following medication incidents for a specified month were identified:

Resident #007 and #054 had medication incident reports regarding having missed a specified injectable medication on a specified date in 2017 as this medication was to be administered every six months and was last provided on a specified date in 2016. The PMRC indicated she did not have a chance to review, analyze, or provide corrective actions to these incidents to date. The PMRC indicated they have had challenges with the new MIRS- a new electronic medication incident reporting system for sure, as they only enter the medication incidents, it does not provide any direction for monthly reviews, trends, or other. [s. 135. (2)]

3. The Licensee has failed to ensure that:

(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b)

On August 9, 2017 the PMRC indicated to Inspector #547 that the quarterly review of medication incidents is done at their professional practice meeting which is held every three months. The last quarterly review was to be done in May 2017 and it was not done as the home had challenges with the new Medication Incident Review System (MIRS). [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident is reported to the resident, the resident's substitute decision-maker, if any, they are reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything and a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything, to be implemented voluntarily.

WN #16: 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:
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 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.

During the initial tour on July 21, 2017 and on July 24, 2017, inspector #547 observed that the visitor's washroom door on the West Wing area of the 2nd floor was opened.

On July 28, 2017, inspector #211 observed the above visitor's washroom door open. Furthermore, inspector #211 observed that the door was not equipped with a lock system.

During interviews with PSW #132 and RN #133 on July 28, 2017, they indicated that the visitor's washroom door on the West Wing area of the 2nd floor was always open and unlocked for the visitor and residents who chose to use this washroom.

During interviews with the Program Manager of Resident Care and the Site Supervisor on July 28, 2017, they indicated that the visitor's washroom on the West Wing area of the 2nd floor was a non-residential area and the door should be equipped with a lock to restrict unsupervised access to that area by the residents.

As evidenced, the visitors washroom on the West Wing area of the 2nd floor which is a non-residential area, was not equipped with a lock to restrict unsupervised access to that area by the residents, and the door was not kept closed and locked. [s. 9. (1) 2.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8, 79. 3. (k) in that the licensee did not ensure that the required information was posted in the home, in a conspicuous and accessible location in a manner that complies with the requirements, if any, established in the regulations. The required information to be posted is:
-copies of the inspection reports from the past two years for the long-term care home.

During the initial tour of the Home on July 21, 2017 and again on July 31, 2017, inspector #550 observed copies of past inspections posted on the bulletin board next to the elevators on the first floor. There were two clip boards, one for the English reports and another one for the French reports. The oldest inspection report on both clipboard was dated December 16, 2016. The previous inspection reports from inspections that were conducted in 2015 were not posted.

On July 31, 2017, during an interview, the Administrator indicated to inspector #550 that all inspection reports since July 2015 should be posted. She stated that someone must have removed them as they were recently revised to ensure that inspection reports for the past two years were posted. She informed the inspector that she will make sure that all the reports from July 2015 to July 2017 are posted. [s. 79. (3) (k)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that an analysis of the restraining of resident #006 by use of a physical device undertaken on a monthly basis.

Resident #006 was admitted to the home in 2015 with several medical diagnoses including dementia. Resident #006 returned from hospital on a specific date in 2017. RN #100 received the resident and documented in the progress notes at a specified time that the physician ordered the abdominal seat belt restraint as part of the discharge plan from the hospital for resident #006. RN #100 documented that the plan of care was updated at this time. RN #145 documented in the progress notes 6.5hrs later on the same day that she had called and got verbal consent for the restraint by the SDM and asked them to come sign the restraint consent form. The SDM signed the abdominal seat belt restraint form two days later.

Resident #006 has been observed by Inspector #547 to wear an abdominal seat belt restraint daily on July 24,25,26,28, Aug 2, 2017.

The Program Manager of Resident Care indicated that restraining of residents by use of a physical device is completed monthly based on the Minimum Data Set (MDS) reports identifying those residents using restraints in the home.

Inspector reviewed the MDS assessments for two specific dates in 2017 for resident #006 and noted that the resident was not coded as using any restraints.

The Program Manager for Resident Care indicated that if resident #006 was not coded in the MDS assessments for restraint, then they would not have reviewed this resident's restraint monthly as required. [s. 113. (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On July 21, 2017 inspector #550 was standing at the nursing station on the third floor unit and observed two medication carts in the hallway close to the dining room entrance. The inspector observed a green light on the locking mechanism of one of the carts near the dining room and walked to the medication cart as there was no staff supervising the medication carts. The inspector observed that the medication cart was unlocked and was able to open several drawers containing resident's medication. The Inspector intercepted a staff member who was pushing a resident in a wheelchair out of the dining room and asked to see a nurse. The staff member indicated she was the RPN and identified herself as RPN#147. The inspector explained concerns regarding the fact that the medication cart was left unlocked and that the inspector was able to open several drawers while the cart was unattended. RPN #147 indicated she did not know why it was unlocked and stated she had locked it. After a few minutes, while speaking to RPN #147, the inspector and RPN heard the medication cart lock itself. Inspector #550 verified the drawers for the medication cart and noted they were now locked.

On July 24, 2017 inspector #547 observed a prescribed cream in a basket in resident #017's bathroom that was not locked or supervised by any nursing staff.

On July 31, 2017 Inspector #547 observed a plastic basket on the second floor outside

the locked medication room that contained prescribed resident creams:

- cream labelled with resident #048's name to be applied to a specific body part twice daily until it is healed.

- cream labelled with resident #049's name to be applied to a specific body part three times a day with occlusive dressing.

- cream labelled with resident #050's name to be applied to a specific body part twice a day. RPN #124 working on the second floor today indicated to Inspector #547 that this resident remains in hospital today, and that this prescribed cream was not required to be applied today and should have remained locked in the medication room.
- cream labelled with resident #051's name to be applied to a specific body part twice daily.

The nursing station was unattended at the time of these observations.

RPN #108 indicated to inspector #547 that she removed this basket of prescribed creams at the beginning of the day shift after the shift report and she indicated to the PSW staff to take their prescribed creams for the residents they are to care for. Inspector #547 asked where the PSWs stored these creams once in their responsibility, and she indicated either in their pockets or on their carts. RPN #108 further indicated that they are expected to return the prescribed cream to the nursing station to the registered nursing staff when they have applied them to the resident and not just placed in the basket outside the locked medication room.

PSW #113, #126 and #127 indicated to inspector #547 that after they take the residents' prescribed cream, they keep the containers in the cart locked in the tub room with linens, and when they are done with applying the prescribed creams to the residents, they return the containers to the nursing station and place them back in the basket located outside of the nursing station. PSW #113 indicated that they assumed the registered nursing staff were always around the nursing stations.

The Program Manager of Resident Care(PMRC) indicated to Inspector #547 that the home's expectation regarding managing prescribed creams is that the PSWs should be asking for the prescribed creams before using them on the residents and returning them to the registered nursing staff when they are done with them. PSWs should not be returning them to the nursing station and placing them in the plastic basket, but should

be giving them directly to a registered nursing staff to lock them up. [s. 129. (1) (a)]

Issued on this 17th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550), JOELLE TAILLEFER (211), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2017_619550_0018
Log No. / No de registre :	013359-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 22, 2017
Licensee / Titulaire de permis :	CITY OF OTTAWA Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	CENTRE D'ACCUEIL CHAMPLAIN 275 PERRIER STREET, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Roy

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The Licensee shall ensure that the written policy to minimize the restraining of residents is complied with. Specifically, the license shall:

1. Provide education to direct care staff on the licensee's "Least restraint" policy. This education shall include a review of the documentation requirements under O. Reg. 79/10, s.110. (7). This education shall be documented.

2. Review the plan of care of residents #003, #006, #046 and #047 and all other residents who are being restrained by a physical device to ensure that any restraining is done in accordance with the Act, the regulations and the licensee's "Least restraint" policy.

3. Develop and implement a monitoring process to ensure that the licensee's "Least Restraint" policy is complied with.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home's policy to minimize the restraining of the residents is complied with.

Inspectors #547 and #550 reviewed the home's restraint policy titled "Least Restraint", policy #335.10, revised January 2017. On pages 4 and 5, "Procedure: Initiation of Restraint" indicated the following:

1. Complete an assessment to determine rationale for considering a restraint. Potential for injury to self or others.
2. Ensure that all possible alternative interventions are attempted prior to applying a restraint (see restraint decision tree).
5. Obtain and document consent or refusal on consent form.
6. Before using, contact the physician and obtain an order for the restraint. The physician must review the restraint order quarterly, and more frequently as required.
7. Fax the physician order to Pharmacy so that the restraint order will appear on the MAR and the Quarterly Medication Review.
8. Document in the progress notes circumstances precipitating to the application of the restraint; alternatives considered and why inappropriate; person who made the order; what device was ordered; consent; person who applied the device and the time of the application.
9. Initiate the Restraint Monitoring Form. Ensure completion using the appropriate key and response.
13. Every release of the device and all repositioning will be recorded on the restraint/PASD flow sheet.
14. Document all assessments, reassessment and monitoring including the resident's response, as well as the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining.
18. The resident's condition is reassessed and the effectiveness of the restraining is evaluated every 8 hours by a member of the registered staff and documented on the MAR.

1. Resident #003 was admitted to the home in 2015 with several medical diagnoses. Resident #003 was observed by inspector #547 to wear a seat belt restraint while seated in a wheelchair on July 24, 25, 26, 27, 28 and 31, 2017.

On July 26, 2017 RN #100 indicated that the resident wears a seat belt restraint when in the wheelchair at all time for safety. RN #100 further indicated that registered nursing staff are responsible to record on the Medication Administration Records (MAR) every shift when the resident is up in the wheelchair, that the seat belt restraint is properly applied and the resident is reassessed every eight hours. Inspector #547 interviewed RN #109 who indicated that the resident's seat belt restraint should have been recorded in the resident's MAR and then signed for every day and evening shift in order for the evaluation of the applied restraint. RN #109 further identified the home's plan of care to include the resident's care plan, PSW documentation flow sheets,

Medication Administration Records (MAR), and the resident's physical and electronic health care records.

Inspector #547 obtained copies of the resident's MAR and observed that there was no documentation for any seat belt restraint identified on resident #003's MAR sheets for the month of July 2017. The resident health care records also did not have an order by the physician or the registered nurse in the extended class for the use and application of the seat belt restraint for resident #003.

RPN #140 indicated to Inspector #547 on July 27, 2017, that the resident had an old order form for restraint dated a specified date in 2015 in the chart signed by the physician. RPN #140 further stated that restraints are to be re-ordered every three months as per the home's policy for restraints and that this had not been completed for resident #003.

Inspector #547 reviewed resident #003's plan of care and no documentation regarding the circumstances precipitating the application of the physical device, what alternatives were considered and why those alternatives were inappropriate. It was noted that there was no order, what device was ordered, and any instructions relating to the order. There was no consent on file. There is no documentation regarding when the restraint was applied and by who or all assessment, reassessment and monitoring, including the resident response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

As such, the home's policy "Least Restraint" was not complied for resident #003's use of a seat belt restraint.

2. Resident #006 was admitted to the home in 2015 with several medical diagnoses. The resident was observed by inspector #547 to wear a seat belt while seated in a wheelchair on July 24, 25, 26, 28 and August 2, 2017.

On July 26, 2017 RN #100 indicated that resident #006 requires a seat belt restraint when in the wheelchair at all time for safety since the resident returned from hospital on a specified date in 2017. RN #100 further indicated that registered nursing staff are responsible to record on the Medication Administration Records (MAR) every shift when the resident is up in the wheelchair and that the seat belt restraint is properly applied as part of the

reassessment of restraints every eight hours.

Inspector #547 obtained copies of the resident's MAR and observed that there was no documentation for the seat belt restraint monitoring and reassessment on ten specified day shifts and twenty three specified evening shifts of a specified month.

RN #100 indicated that when the MAR is not signed, it means that it was not done.

RN #109 further identified that the resident's care plan includes PSW documentation flow sheets, Medication Administration Records (MAR), and the resident's physical and electronic health care records. Inspector #547 reviewed resident #006's plan of care as identified by RN #109 and was not able to find any documentation regarding the person who applied the restraint device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. RN #100 indicated to Inspector #547 that they must have forgotten to add the monitoring forms in the home's flow sheet binders for this resident.

As such, resident #006's condition was not reassessed and the effectiveness of the restraining was not evaluated every 8 hours by a member of the registered staff and documented on the MAR. There was no documentation regarding the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

3. Resident #046 was admitted to the home in 2015 with several medical diagnoses.

Resident #046 was observed by inspector #547 to wear a seat belt when seated in a wheelchair on July 24, 25, 26, 27, and 28, 2017.

On July 26, 2017 RN #100 indicated that the resident wears a seat belt restraint when in the wheelchair at all time for safety. RN #100 further indicated that registered nursing staff are responsible to record on the Medication

Administration Records (MAR) every shift when the resident is up in the wheelchair, that the seat belt restraint is properly applied and the resident is reassessed every eight hours.

RN #133 indicated that the PSW's do not have access to the home's electronic documentation system and use the paper care plans and flow sheets located in binders at the nursing stations.

Inspector #547 obtained copies of the resident's MAR and observed that there was no documentation for any seat belt restraint identified on resident #046's MAR sheets for the month of July 2017. Inspector #547 reviewed resident #046's plan of care and flow sheets and observed there was no documentation for the seat belt restraint, the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

As such, the home's policy "Least Restraint" was not complied with for resident #046's use of a seat belt restraint.

4. Resident #047 was admitted to the home in 2009, with multiple medical diagnoses. The resident was observed by inspector #550 on August 2, 3 and 4, 2017 at various times during the day to have a seat belt with a sleeve cover in place when seated in the wheelchair.

On August 4, 2017, RN #102, PSW #140 and PSW #150 indicated to the inspector that resident #047 is to have a seat belt with a sleeve cover applied when seated in the wheelchair to prevent falls.

The inspector reviewed the resident's health care records on August 4, 2017. The "Prescribed Medical Guidelines" form for resident #047 contained a physician order for the seat belt restraint dated a specified date in 2016, renewed two months later and then one month later. It was documented on the MAR by the registered nursing staff for the months of June, July and August on days and evenings that the restraint was verified. There was no documentation whether the restraint had been used or not during the night shift. The inspector was not able to find any documentation regarding the application, the monitoring, repositioning of the resident, the discontinuance and the resident's

reaction to the use and application of the restraint prior to August 1, 2017.

Staff are to document on the restraint check form using this legend on the top of the form:

Key:
A - applied
V - visual observation
D - declined/refused (see progress notes)
P - in place
R - removed

Reaction:
0 - no reaction/calm
1 - agitated
2 - attempts to remove

On August 1, 2017, a "restraint check form" was initiated for resident #047 and noted the following:
-the prescribed restraint, the month and the year were left blank
-August 1: the restraint was applied at a specified time, there was a check mark hourly for a period of eight hours and in the column for the resident's reaction, and there was a "0" at the time the restraint was applied. No other documentation for that day.
-August 2: the restraint was applied at a specified time, and in the column for the resident's reaction, there was a "0" at the time the restraint was applied. No other documentation for that day.
-August 3: There was no documentation for that day.
There was no documentation regarding the repositioning of the resident and the post-restraining care.

On August 4, 2017, the Program Manager for Resident Care indicated to the inspector that the PSWs are required to document the application, the person who applied the restraint and the time, the monitoring, the discontinuance and the resident's reaction to the restraint on the "restraint check form" and that this form was implemented on August 1, 2017 after the revision of their restraint policy in January 2017. Before August 1, 2017, there was no documentation done except for the evaluation of the resident's condition and the effectiveness of the restraining done every eight hours by the registered nurses on the MAR.

She indicated that the "restraint check form" has no provision to allow the PSWs to document the repositioning of the resident and the post-restraining care. In reviewing the MAR and the "Prescribed Medical Guidelines" form with the inspector, she indicated that the registered staffs are to evaluate the resident's condition and the effectiveness of the restraining and document this in the MAR every eight hours; not just verify the restraint in the wheelchair as currently indicated on the MAR and that this is to be done every eight hours; not just on days and evenings. The physician has to review the restraint order at least quarterly.

As such, resident #047's condition was not reassessed and the effectiveness of the restraining was not evaluated every 8 hours by a member of the registered nursing staff and documented on the MAR. There was no documentation regarding the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. The physician did not review the restraint order quarterly as per their policy.

As evidenced above, the home's "Least Restraint" policy was not implemented for residents #003, #006, #046 and #047.

The scope and the severity of this non-compliance were reviewed. The fact that the home's restraint policy is not complied with is widespread and poses a risk for potential harm to all the residents who are being restrained. Non-compliance was previously issued as a voluntary plan of correction on March 8, 2017. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 11, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Joanne Henrie

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