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
Nov 8, 2017	2017_643111_0013	002637-17, 003590-17, 004285-17, 005741-17, 006958-17, 008774-17, 009287-17, 009329-17, 013929-17, 014938-17, 014980-17, 015397-17, 016984-17, 017491-17, 018204-17, 019022-17, 020744-17, 021111-17	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 VALLEY FARM ROAD PICKERING ON L1V 3R6

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

LYNDA BROWN (111), CRISTINA MONTOYA (461), PATRICIA MATA (571), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 10, 11, 14-18, 21-25, 28-31, September 1, 5-8 and off-site October 4, 2017.

The following complaint inspections were completed concurrently during this inspection:
Log # 003590-17, 014938-17 & 013929-17 related to insufficient staffing;
Log # 009287-17, 008774-17 & 017491-17 related to alleged staff to resident neglect;

Log # 014980-17& 016984-17 related skin and wound care and resident charges;
Log #018204-17, 005741-17 & 009329-17 related to alleged resident to resident abuse;
Log#002637-17 related to responsive behaviours;
Log #006958-17 related to medication incidents;
Log #004285-17 related to end of life care and pain management;
Log # 019022-17, 021111-17 & 020744-17related to falls and complaints.

In addition, the following critical incident reports were completed concurrently during this inspection but non-compliance was identified in this report as they were directly related to the complaints:
Log # 017305-17 related to alleged staff to resident neglect;
Log # 016955-17 related to alleged staff to resident abuse;
Log # 008920-17 & 015397-17 related to alleged resident to resident abuse;

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Director of Quality Nursing, Nursing Administrative Assistant, Program Director, Nutrition Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Supervisor(FSS), Resident Care Area Managers (RCAM), Therapy Nurse (ET Nurse), Electrical Safety Authority (ESA), College Of Trades, Public Health Unit Inspectors, Behavioural Supports Ontario (BSO) staff, Social Worker, Recreation Aide, Operations Manager, Corporate Consultant, Former Acting DOC, Physiotherapist Assistant (PTA), Physiotherapist (PT), Occupational Therapist (OT), Administrative Assistant, Environmental Services Manager (ESM), Environmental Services Supervisor (ESS), contractors, and residents.

During the course of the inspection, the inspector(s) also reviewed health records, investigations, staff training records, complaint logs, observed meal services and reviewed the following policies: Zero Tolerance of Abuse and Neglect, Pain

Management, Skin and Wound care Program, Falls Prevention, Complaints, Staffing Plans, Contractors and Nutrition and Hydration.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **5 CO(s)**
- **3 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A. There were multiple complaints received through the Ministry of Health and Long-Term Care Action Line related to personal support staffing shortages impacting resident's care.

Interview with DOC by Inspector #111, indicated that the home is divided into 6 units (Aspen, Linden, Maple, Cedar, Birch and Pine). The DOC indicated Pine unit is the largest unit and has 49 residents.

Review of the Personal Support Workers (PSW) staffing schedule for a specified month in 2017 for a specified unit indicated there were a specified number of days when the unit was working short- staffed.

Interview with Nursing Administrative Assistant (Staff #120) by Inspector #111, indicated the home usually has the most short-staffing (with PSWs not at full compliment) on two specified units and usually occurs on specified shifts. Staff #120 indicated they are from sick call-ins or no-shows and usually occur over a four day period, resulting in the units working short-staffed (not working at full PSW compliment).

Interview with the Administrator by Inspector #111, indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff on two specified months in 2017 related to concerns with staff no-shows and attendance concerns (111).

B. Related to log #017491-17 & # 008774-17:

Review of the Resident Council meeting minutes for 2017 by Inspector #461 indicated in a specified month, the residents expressed concerns related to inconsistency in PSW staffing, residents not receiving the same PSW on a regular basis and happening for the past six months. There was also a concern that the breakfast for a specified unit in the dining room was always late, PSWs were still getting residents ready for the day and not able to be in the dining room to provide assistance with feeding/serving, was consistently short-staffed within the nursing department resulting in inconsistency with staff providing care to residents. Review of the Resident's Council meeting minutes for four specified

months, indicated the residents were unhappy with changes in the dining room times and wanted the breakfast time changed back to 0815 hours. Residents indicated the service was too rushed and there was not enough time between breakfast and lunch.

On a specified date, Inspector #461 observed the breakfast meal service (scheduled to start at 0845 and to finish by 0930 hours) in all dining rooms. The large main dining room was divided by the various home areas: Linden, Birch, Maple, and Pine. Inspector #461 observed at 0845 hours, residents were being served fluids only and the actual meal service did not commence until 0900 hours. There were residents also noted to be missing from the dining room. The breakfast meal service was still occurring at 0945 hours.

Interview with RPN #127 and PSW #141 on a specified date by Inspector #461, indicated that a specified unit had been short-staffed for the past five days. Both staff indicated on this specific date they were also short-staffed (not at full PSWs compliment) which lead to residents arriving late for breakfast. PSW #141 indicated at 0900hours, there were six residents still waiting to be taken to the dining room for breakfast.

On a specified date, during separate interviews with the Nutrition Manager #114 and Program Director #126, by Inspector #461, both indicated the breakfast start time was changed from 0815 to 0845 hours on a specified date without input from the Resident's Council. The Nutrition Manager indicated the start of breakfast time was changed because PSWs did not have enough time to bring all the residents to the dining room for breakfast.

On a specified date, Inspector #461 observed the main dining room for breakfast and noted the following: at 0845 hours, staff were noted still bringing residents into the dining room for breakfast; at 0900 hours, a PSW reported that they were still waiting for 2 residents to arrive; at 0905 hours, approximately 30 residents were sitting at their tables with just their drinks and had not yet received the hot cereal or any other breakfast items. The residents were not offered hot cereal until approximately 0920 hours; at 0910 hours, table #7 had four residents seated, including resident #022. The resident asked the Inspector for hot cereal (as there was no staff to assist) and indicated the resident had been waiting for approximately 15 minutes. At the same table, only 1 out 4 residents had received their hot cereal; at 0920 hours, the Inspector noted one resident was waiting to be brought to the dining room for breakfast. The resident was brought to the dining room at 0925 hours. There were still several residents in main dining room (specifically on Birch and Pine unit) that were still having breakfast after 0930 hours.

Interview with the Operations Manager (former acting Administrator) by Inspector #571, indicated that breakfast time was changed from 0815 to 0845 hours because when breakfast was served at 0815 hours, three quarters of the residents were not in the dining room to begin the breakfast meal. The former interim Administrator indicated with change in meal time, the breakfast meal was now completed between 0915 and 0930 hours. The former interim Administrator confirmed that an evaluation of the time change had not been completed to determine if the meal time change had been effective.

On a specified date, Inspector #461 observed the main dining room for the breakfast meal, and noted the following where residents from a specified unit were located: at 0850 hours, the residents had not yet received their fluids and there were no PSWs available to assist with meal service; at 0905 hours, residents were still arriving to the dining room and at 0910 hours, PSW #168 from the Birch unit arrived to the dining room and starting serving the residents on this unit; at 0925 hours, all four PSWs from the Birch unit were now present in the dining room. At 0930 hours, resident #012 was provided the main course of breakfast. Resident #012 stated to the Inspector the meal service at breakfast "was late almost every day". At 0938 hours, resident #025 arrived to the dining room, PSW #124 indicated that resident usually comes to the dining room independently but needs reminders, because they were short a PSW staff, the resident was forgotten in their room. Resident #025 received the breakfast meal at 0942 hours. At 1000 hours, resident #026 was served the breakfast meal, despite being seated in the dining room since 0850 hours. At 1005 hours, PSW #168 had prepared food trays for residents on isolation (resident #027, #029, and #030). The PSW has also prepared a fourth tray for resident #032. The PSW reported to the Inspector that resident #032 normally came to the dining room but the PSW did not have time to get the resident up for breakfast. PSW #168 also indicated that being short-staffed greatly affected the care provided to residents in the morning. The breakfast meal service on this date did not conclude until 1030 hours. Inspector #461 noted the morning snack was to be served at 1030 hours and lunch provided at 1200 hours. The home was not providing adequate time between the breakfast and the lunch meal to promote healthy appetite and ensure adequate nutritional intake for residents.

During an interview with the Administrator by Inspector #461, indicated awareness of the residents getting to the dining room late for breakfast and therefore not leaving the dining room until after 0930 hours. The Administrator also indicated the breakfast time change was yet to be evaluated (461).

C. Related to log # 003590-17 & # 002637-17:

Interview with resident #017 by Inspector #111 indicated the regular PSW was away for a specified period of time and ever since then, the resident has had a new PSW every day. The resident also indicated the resident was supposed to have a shower and hair washed in the morning approximately a week ago, but the staff were too late getting to the resident due to PSW short-staffing. The resident indicated the shower was refused because of an appointment at that time and was upset.

Interview with PSW #147 by Inspector #111, indicated resident #017 has a shower two days per week. The PSW indicated the resident prefers to have the shower before breakfast but the staff cannot always provide the shower at that time. The PSW indicated the shower sometimes has to be later in the morning due to PSW short-staffing (PSW not working at full compliment) and the resident will then refuse (111).

D. Related to log # 017305-17:

A critical Incident Report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect. The CIR indicated resident #014 had reported a verbal complaint the resident was not toileted as requested two days prior for a period of two hours.

Review of the resident #014 health record, review of the licensee's investigation and interview of staff (PSW #134 & #135) by Inspector #111, indicated on a specified date and time, resident #014 had rang the call bell and requested assistance with toileting. Resident #014 required two staff assistance with a mechanical lift. PSW #134 indicated he/she would get assistance and the mechanical lift and return but did not return until approximately two hours later with PSW #135. The resident was incontinent, was upset and crying as a result. PSW #134 indicated that they were working short-staffed (PSW not working at full compliment) that evening and had to wait for PSW #135 to be able to assist with toileting (111).

E. Related to log # 014938-17:

An anonymous complaint was received by the Director regarding the home always working short-staffed (PSWs not at full compliment), especially in the evenings, and on the unit with 49 residents.

Interview with PSW #140 on a specified unit by Inspector #111, on a specified date indicated the unit was working short-staffed today (PSW not at full compliment) and has worked short-staffed for the last five days in a row. The PSW reported to Inspector #461 that the staff were late getting residents to the dining room for breakfast (not until after 0900 hours) as a result. In an interview with PSW #140 on a specified date by Inspector #111 indicated the same specified unit has been short-staffed on a specified shift every day for last two weeks.

Interview with PSW #123 & #125 and RPN #121 on a different specified unit by Inspector #111 on a specified date, indicated they frequently work short- staffed, usually 3-4 times per week. The PSW's indicated they were working short-staffed again today. The PSW's indicated they were a half hour late getting the residents down to the dining room for lunch as a result. The PSW's indicated one PSW had to remain on the floor to assist with toileting during the meals so they only had 3 PSW's to assist with feeding 41 residents.

Interview with the Administrator by Inspector #111 indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff in two specified months related to concerns with staff no-shows and attendance concerns.

The severity of this non-compliance indicated that there was potential for harm/risk as the organized personal support staffing was not meeting the needs of the residents, and the scope was a demonstrated pattern as there was two out of six resident units where the PSWs were noted not working at full compliment. This impacted the resident care by the following: resident #014 was not toileted as requested for a period of two hours, resulted in the resident being upset; several residents on two specified units were not receiving their breakfast meals in the dining room and/or within the designated meals times (despite the meal time being changed to a later time). Not providing adequate time between the breakfast, morning snack, and the lunch meal does not promote healthy appetite and ensure adequate nutritional intake for those residents; and resident #017 who requested showers to be provided before breakfast to accommodate an appointment, was occasionally not receiving a shower on those days when PSWs were work short-staffed (111).

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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

Findings/Faits saillants :

The licensee has failed to ensure that residents are not charged for goods and services that they are required to provide using funding.

Related to Log #014980-17:

A review of the Family Council meeting minutes for a specified date, by Inspector #571 indicated that foot care was an unfunded service and in future, a charge of twenty five dollars would be charged to those residents and the service would be provided every eight weeks. The minutes indicated the service was optional and another provider could be chosen. Review of a memo, with a specified date, indicated that effective June 13, 2017, residents would be charged for foot care services as historically, the home provided the unfunded service at no charge but were no longer able to continue.

In an interview with Extendicare Operations Manager (former acting Administrator) by Inspector #571, clarified that the memo and Family Council meeting minutes were referring to advanced foot care only. The Operations Manager indicated that the licensee was previously providing advanced foot care at no cost to the residents and since advanced foot care was an unfunded service, the licensee decided to hire an outside advanced foot care nurse to provide advanced foot care services to residents. The Operations Manager indicated the total advanced foot care charge was thirty five dollars which included: thirty dollar charge for the foot care nurse and five dollar charge that was used to pay a PSW (employee of the home) to porter the residents to a central location in the home for the foot care service.

In an interview by Inspector #571 with the Administrator, indicated that the advanced foot care was provided in each resident room rather than in a central location. The Administrator indicated, the advanced foot care service by an outside provider was a new process and the licensee was still working on the process.

The licensee provided a list to Inspector #571 that indicated 84 residents had been charged and paid for the 35 dollar advanced foot care, which included the five dollar portering charge, since June 13, 2017.

The licensee receives funding through the nursing and personal care envelope from the Ministry of Health and Long Term Care. Such funding would include portering of residents to all areas within the long term care home. Therefore, the five dollar charge for portering is prohibited (571).

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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 falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

The licensee has failed to ensure there was an interdisciplinary falls prevention and management program fully implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Related to log # 020744-17:

Review of progress notes for resident #037 indicated in 2017 the resident sustained twelve falls over an eight month period. After the sixth fall, and concerns expressed from the family of the resident, two devices were implemented to reduce potential injury. The resident was transferred to hospital after the 11th fall.

Interview with Physiotherapist (PT) #186 by Inspector #111 indicated he/she usually receives a referral for any residents who have fallen (either on paper or electronically) and both the PT and PTA's review Point Click Care (PCC) daily for any residents who have fallen. The PT indicated when a referral is received, they would complete an

assessment and provide strategies for falls prevention. The PT indicated resident #037 was previously a moderate risk for falls but then changed to a high risk for falls after returning from hospital (post fall). The PT was aware resident #037 was having frequent falls. The PT indicated he/she had not attended any Falls Prevention Program meetings in 2017 and indicated the Falls Prevention Lead was RCAM #188.

Interview with Physiotherapy Assistant (PTA) #183 by Inspector #111 indicated the SDM of resident #037 inquired about a tilt wheelchair to prevent further falls and the PTA notified the Occupational Therapist (OT) to complete a seating assessment. The PTA indicated awareness the resident was sent to the hospital post fall. The PTA indicated awareness of other falls prior to hospitalization. The PTA indicated upon return from hospital, the resident was confined to a wheelchair.

Interview with RCAM #188 by Inspector #111 indicated he/she was the lead for falls prevention program but indicated has not been able to have any meetings for the last six months. Indicated the last documented meeting was approximately seven months ago. The RCAM indicated resident #037 was a high risk for falls and was aware the resident had several falls in the last couple of months. The RCAM indicated he/she reviewed the previous month falls that were occurring in the home and noted that resident #037 had been having several falls, but had not been able to review plan of care. The RCAM also indicated awareness of concerns with family regarding an injury prevention device that was not effective and the families request to reassess the device, but not sure of exact date this concern was brought forward or actions taken.

Resident #037 sustained 11 falls since the Falls Prevention Team last met. There was no indication that the Falls Prevention Program was implemented with the aim to reduce the incidence of falls and the risk of injury until after the family expressed concerns.(111) [s. 48. (1) 1.]

2. The licensee failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was fully implemented in the home.

A review of the licensee's Skin and Wound Program: Prevention of Skin Breakdown (RC-23-01-01) and Wound Care Management policy (RC-23-01-02), last updated February 2017 indicated the program gives directions including the following:
- RC-23-01-01: to designate a Wound Care Lead to coordinate the program and work with the interdisciplinary team to ensure program implementation and effectiveness;

conduct wound rounds and quality improvement reviews regularly. Appendix 1 directs the nurse to inform Wound Care Lead, Physician/Nurse Practitioner (NP) of any new and/or worsening skin breakdown and as need; complete surveillance as required.
-RC-23-01-02: the Nurse or Wound Care Lead to: promptly assess all residents exhibiting altered skin integrity on initial discovery; use a Bates Jensen Wound Assessment Tool for pressure ulcers/venous stasis or ulcer of any type; use an Impaired Skin Integrity Assessment Tool for all other skin impairments (i.e., skin tears, rashes, reddened areas, bruises); monitor resident skin condition with each dressing change, re-assess at minimum weekly; re-evaluation and documentation of treatment with creams and other medicated preparations should occur at minimum weekly; initiate one Bates-Jenson Wound Assessment for each open area/wound; complete the Bates-Jensen Assessment if condition worsening or not improving as expected, but at a minimum every seven days; photograph pressure ulcers and complex wounds as needed to track healing and assess treatment effectiveness;

Related to Log # 016984-17:

Resident #005 was admitted to the home with diagnoses that included alteration in tissue perfusion, history of skin breakdown and wounds to specified areas. The resident was hospitalized on two separate occasions related to wounds since admission. A review of the clinical health record over a seven month period, from the time of admission, indicated the following:
-the following month after admission, the resident's wounds were assessed by an Enterostomal Therapy (ET) Nurse and new treatments were ordered for wounds to specified areas.
-the following month, the dressings and the wounds, on specified areas, were noted to have a foul smell. A week later, moderate, foul smelling drainage was noted from specified wounds. A week later, a specified wound had a change in the amount and type of discharge. A week later, the resident was assessed by the ET Nurse and recommended a new treatment, and suggested antibiotics for specified wounds due to infection.
-the following month, resident was reassessed by the ET Nurse, the resident was sent to hospital due to skin related changes to specified areas and treated with antibiotics. The resident returned from hospital a month later and continued the antibiotic therapy. A week later, another wound to a specified area was noted to be deteriorating. A week later, dressing changes to specified wounds indicated excessive bleeding and the Physician was notified. The Physician discontinued specified treatments.
-two days later, a specified wound was noted to further deteriorate and was reported to

the Resident Care Area Manager (RCAM). A referral was made to the Wound Care Lead.
-three days later, a Weekly Impaired Skin Integrity Assessment was completed and indicated the wound over one specified area had deteriorated further, and identified four other areas with altered skin integrity.
-three days later, a Bates-Jensen Assessment was completed and indicated the wound to a specified area had deteriorated further.
-a week later, the Weekly Impaired Skin Integrity Assessment indicated the wound to a specified area was larger and further deteriorated.
-a week later, a Bates-Jensen Assessment indicated the wound to a specified area was larger and the four other wounds to specified areas were also getting larger. There was also two additional wounds noted.
-a week later, all wounds were noted to have large amount of foul smelling drainage and the resident was crying out in pain. The Physician was contacted and the resident was transferred to hospital for assessment.

A review of the clinical health records for resident #005 indicated over a seven month period in 2017, the Bates-Jenson skin assessment was completed as follows:
-on a specified date, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed.
-the following month, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed. o
-two months later, one incomplete assessment was completed for a specified area which was lacking wound measurements.
-six days later, one assessment was completed for a specified area with multiple skin breakdown to specified areas.
-the following month, one assessment was completed for a specified area with specified measurements.
-the following month, one assessment was completed for five different specified areas with specified measurements. The specified areas measured larger than the previous month with additional areas.
-the following month, one assessment was completed for multiple wounds to two specified areas.
-six days later, one assessment was completed for two wounds to a specified area and

In an interview with Inspector #571, RPN #117 indicated that resident #005 had returned from the hospital on a specified date with a wound to a specified area and described the wound. RPN # 117 indicated no awareness of requirement to complete weekly Bates-Jensen assessments for specified types of wounds. RPN #117 indicated the RCAM/Wound Care Lead (#130) was notified of the wound.

In an interview with Inspector #571, RCAM/Wound Care Lead (#130) indicated that resident #005 was admitted to the home with multiple wounds so he/she arranged to have an Enterostomal Therapy (ET) Nurse come in to assess resident #005's wounds monthly. The ET Nurse did not assess the resident in one specified month as the home was in outbreak. RCAM #130 indicated that he/she had just become aware that the Bates-Jensen wound assessments had to be completed for all wounds, not just pressure ulcers. RCAM #130 indicated that the Skin and Wound Program policy was new and that he/she is still learning about the Program. In addition, he/she indicated the nurses were to track all wounds on the wound tracking form but that the forms were not always completed. The RCAM indicated when a resident had a new, challenging or worsening wound, staff were to submit an electronic referral to the wound care lead but he/she was not always able follow up on the referrals right away. The RCAM indicated wounds were not photographed in the home.

There was no documented evidence to indicate the Bates-Jensen weekly skin assessment (the clinically appropriate assessment instrument) was completed 17 times during a five month period for resident #005's multiple wounds. The Bates-Jensen assessments were not completed weekly for each of the wounds that resident #005 had, it was not clear when the resident started to display signs and symptoms of a specified tissue alteration diagnosis and this diagnosis was not discovered until the NP completed a monthly assessment of the resident and sent to the hospital. Also, it was unclear what the status of resident #005's wounds were from week to the next week and exactly where the wounds were located, as the licensee was not ensuring that registered nursing staff were using a Bates-Jensen tool weekly for each wound.

There was no documented evidence that photographs were taken of any of resident #005's wounds. There was no documented evidence to indicate that the physician or Nurse Practitioner was notified when resident #005's wounds displayed signs and symptoms of infection on a specified date (wounds were noted to be foul smelling), until the ET Nurse completed the monthly wound assessment approximately three weeks later and recommended antibiotics. There was no documented evidence to indicate that the

physician or Nurse Practitioner was notified when resident #005's wounds were increasing in size (deteriorating). The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

Since resident #005's admission to the home, resident #005 developed and/or had multiple, worsening wounds and included infection to her bilateral arms and legs that resulted in two hospitalizations. In addition, a wound over the left Achilles tendon deteriorated from 4 cm long by 3 cm wide on June 1, 2017, to 12cm by 7.5 cm with an exposed tendon on July 9, 2017. The licensee failed to ensure that correct documentation, assessment or follow-up was conducted as per their Skin and Wound Program. A Compliance Order was issued as a result under O. Reg. 79/10, s. 48 (1) 2., due to the severity and negative outcome towards resident #052. [s. 48. (1) 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the interdisciplinary falls prevention and management program is fully implemented in the home, with the aim to reduce the incidence of falls and the risk of injury., to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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

Findings/Faits saillants :

The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to food allergies.

Related to log # 008774-17:

An anonymous complaint was received by the Director on a specified date, indicating that resident #003 had an allergy to a specified food item and was being offered the specified food item at meal times.

Record review for resident #003 indicated an allergy to the specified food item was listed

on both the written plan of care and listed under allergies on the electronic health record (under the profile tab). Review of the diet list used as reference for staff to serve meals, indicated the specified food item was listed as a dislike and not as an allergy. Review of the Registered Dietitian (RD)'s most current assessment completed, indicated the resident disliked the specified food item and did not identify the specified food item as an allergy.

During an interview with PSW #118, PSW #133 and RPN #116, by Inspector #461, PSW #118 indicated resident #003 was allergic to the specified food item; PSW #133 did not know that resident had an allergy or dislike for the specified food item; RPN #116 indicated that the resident had no allergies to the specified food item.

During an interview with RD by Inspector #461, indicated resident #003 had no allergy to the specified food item and was more of a dislike, according to the resident's POA. The RD confirmed that the instructions to the staff around resident #003's food allergies and dislikes were not clear.

The written plan of care for resident #003, did not set out clear directions for staff and others who provide direct care to the resident related to food allergies. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan, related to toileting.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated two days before at a specified time, the resident was not toileted for a specified period of time.

Review of the written plan of care for resident #014 (in place at time of incident) under toileting/continence indicated: the resident was incontinent, wears an incontinence product, requires two staff assistance with mechanical lift and the resident to be reminded to use call bell when assistance is required.

Review of the licensee's investigation, review of resident #014's health record and interview of staff indicated: on a specified date and time, the resident had rang for assistance with toileting. PSW #134 responded to the call bell and informed the resident

she/he would have to get the mechanical lift and a co-worker (PSW #135) to assist with toileting. The PSW indicated PSW #135 was unable to return to assist the resident for a specified period of time. The PSW returned to the resident approximately two hours later and the resident was upset as a result. PSW #134 indicated no other staff were asked to provide assistance with toileting despite two other PSW's working on the unit and indicated they were working short-staffed that evening as well (111).

B. Related to Log # 019022-17:

A review of the written care plan for resident #021 (at time of incident) indicated under toileting, an intervention (initiated prior to the incident) directing staff not to leave the resident unattended on the toilet. An intervention of an alarming device was also to be used to alert staff when the resident was going to the bathroom.

Review of the progress notes for resident #021 indicated that on a specified date and time, resident #021 was found sitting on the bathroom floor, with an injury to a specified area. The PSW reported the resident had been left on the toilet unattended by a staff member.

In an interview with Inspector #571, RPN #192 indicated resident #021 had history of multiple falls. The RPN indicated on a specified date, when resident #021 sustained the fall, the resident was left unattended on the toilet by a PSW.

On a specified date and time, Inspector #571 observed resident #021 sitting in a mobility aide in his/her room. The resident then proceeded to enter the bathroom and attempted to self-transfer to the toilet. The alarming device did not activate and the Inspector noted the alarming device was turned off.

In an interview with RPN #179 by Inspector #571, indicated that she/he has to remind staff all the time to not turn off the alarming device.

The licensee failed to ensure that the care set out in the plan of care related to toileting was provided to the resident as specified in the plan, specifically, the alarming device and supervision with toileting.

A Compliance Order was warranted as the Licensee has had ongoing non-compliance with ensuring resident's plan of care were provided to residents, as specified in their plan, related to LTCHA, 2007, s.6(7). The Licensee was issued a Written Notification (WN) for

s.6(7) under Compliance Order (CO)#002 for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on November 30, 2015. LTCHA, 2007, s.6(7) was issued as a WN on June 8, 2015 during a critical incident inspection (#2015_293554_0009). LTCHA, 2007, s.6(7) was issued as a (CO) on July 5, 2016 during the RQI inspection (#2016_327570_0014) and was returned to compliance on January 9, 2017. The Licensee was issued a (WN) for LTCHA, 2007, s.6(7) on October 4, 2016 during a complaint inspection (#2016_327570_0022). The Licensee was also issued a (WN) for s.6(7) under Compliance Order (CO)#003 for LTCHA, 2007, s.19 (1) on January 16, 2017 during a RQI inspection (#2017_360111_0001) with a compliance date of June 30, 2017. [s. 6. (7)]

3. The licensee failed to ensure when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care related to pain management.

Related to logs #006958-17 and #008774-17:

On a specified date, during an interview with the complainant by Inspector #461, indicated that resident #003 had been on the same pain medication for over six months and had requested the resident's pain medications be reviewed as the resident continued to complain of pain to a specified area.

Review of resident #003 current written plan of care related to pain management indicated that resident had chronic pain due to a specified diagnosis and interventions included: registered staff to report to physician if medications are ineffective in managing resident's pain.

Review of resident #003 progress notes indicated on a specified date in 2016, the resident's family member reported to RN #019 that the resident's pain to a specified area was worsening. RN #109 assessed the resident' and identified the pain was 6 out 10 on the Bates Jensen Faces Pain Scale. The resident described the pain as sharp and the only time the resident did not experience pain was when sleeping. The RN spoke with the physician who provided a referral to the BSO team, the pharmacist to review resident's medication and a referral to a pain specialist. RN #109 indicated the pain consultation was cancelled as resident was in the hospital, and that consultation would be rescheduled at a later date. There was no indication the consultation was rescheduled.

During an interview with RPN #116 by Inspector #461, indicated resident #003 never had a consultation with the pain specialist or the BSO team.
During interview with Physiotherapy Assistant (PA) #128 by Inspector #461, indicated resident #003 still complained of pain to a specified area every time the PA completed exercises to the specified area. PA #128 indicated that resident's pain level had not changed in the last six months.

Review of the electronic Medication Administration Record (eMAR) for resident #003 for a three month period indicated the resident was ordered and received two oral and one transdermal pain medications.The resident received one of the oral analgesics seven times over the three month period when the resident's pain level ranged from 4-5 out of 10 on the pain scale. The most recent pain assessment completed on a specified date and time indicated the resident presented a pain level of 6 out 10, but no analgesic was administered.

During an interview with RN #109 with Inspector #461, indicated she/he was concerned about the resident's pain to a specified area during a specified month in 2016 and asked the physician for a pain consultation. The RN stated the consultation and the BSO "fell through the cracks and never took place". The RN indicated the resident continues to experience chronic pain to the specified area and requires a pain consultation.

Resident #003 was reassessed, but the plan of care was not revised when care set out in the plan had not been effective, and different approaches considered, related to pain management (461).

4. The licensee failed to ensure when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care related to falls prevention.

Related to log # 020744-17:

A verbal complaint was received by the Licensee from the family of resident #037 on a specified date, regarding the resident sustaining numerous falls in a specified month in 2017. The complainant indicated the resident was provided with fall protective equipment as result of the complaint. The family expressed concern to the home regarding an improper fit of one of the fall protective equipment but no actions were taken.

Review of the progress notes for resident #037 indicated the resident sustained 12 falls in 2017. In two specified months, the resident sustained most of the falls. After the second fall, specified interventions were implemented. After the sixth fall, the SDM was very upset and fall protective devices were suggested and implemented. Staff were reminded to ensure fall protective equipment was in place after the eighth and ninth fall. After the eleventh fall, when the resident was transferred to hospital, staff indicated the resident did not like to use the fall protective devices, would remove them and refused to use the assistive device.

Review of the written plan of care for resident #037 (revised after the fifth fall) indicated the resident was a high risk for falls. Interventions included: has a mobility aide but does not use, seek out resident's whereabouts to ensure the resident has not fallen, alarming device to be in place, fall protective devices to be in place due to recent increase in falls, monitor daily for change in mental status, identify root cause of falls, falling star, bed rails removed, and Hi/Lo bed with bed kept in lowest position.

Telephone interview with Occupational Therapist (OT) by Inspector #111, indicated he/she was aware of resident #037 having frequent falls and root causes. The OT indicated a referral was received on a specified date for a seating assessment, completed the seating assessment, recommended the use of a specified mobility aide and the mobility aide was ordered as the family agreed. The OT indicated no awareness related to concerns with a specified fall protective device.

Interview with PSW #196 by Inspector #111 indicated resident #037 was a high risk for falls and used a mobility aide with an alarming device. The PSW indicated the resident no longer used the specified protective device as the resident would remove the device.

Interview with RPN # 197 indicated the resident was a high risk for falls and a specified protective device was discontinued recently at the family's request.

Interview with RCAM #188 by Inspector #111 indicated she/he was the lead for falls prevention program. The RCAM indicated resident #037 was a high risk for falls and indicated awareness the resident had sustained several falls in two specified months.The RCAM indicated awareness of concerns from family regarding a specified fall protective device that was improperly fitted and the RCAM had requested a proper fitting protective device from OT but not sure of exact date.

The plan of care was not revised, and different approaches considered when the interventions used where demonstrated to be ineffective, as the resident continued to fall. The resident sustained 8 falls before additional interventions were considered (protective devices) and only as a result of the family expressing concerns. The protective device was also noted to have an improper fit and intervention of a proper fitting device was discussed but never implemented. An additional intervention (mobility aide) was also not considered until the family again expressed concerns regarding the ongoing falls (and after the resident sustained four more falls). [s. 6. (11) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: 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 :

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

Review of the Licensee's policy "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (updated April 2017):
-(RC-02-01-01), page 3/8, promptly investigate resident to resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.
-(RC-02-01-02), anyone who witnesses or suspects abuse or neglect of a resident by

another resident, staff or other person must report the incident. Staff must complete an internal incident report and notify their supervisor. The Nurse would then call the Manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident.Management will promptly and objectively report all incidents to external regulatory authorities.On page 2/5, the Administrator has the authority to place an employee on Leave of Absence with pay, pending the results of the investigation. On page 3/5, all staff are to ensure the safety of and provide support to the abuse victim(s) through completion of full assessments, a determination of residents needs and a documentation plan to meet those needs. Other specialized supports to resident/families involved in the alleged incident (e.g. social work counselling). In case of physical and/or sexual abuse, accurate detailed descriptions of injuries/condition are documented in the resident chart.
- (RC-02-01-03), page 3/5, the Administrator or designate, immediately advise the employee that they are being removed from the work schedule, with pay, pending the investigation, the investigating manager/supervisor will: fully investigate the incidents in keeping with the step as outlined in the investigation toolkit; Under Appendix 2, page 2/8, collect employee statements; page 4/8, prior to the start of your interviews, create a list of all witnesses who have direct or indirect knowledge of the incidents, take note to add them to you interview list; page 5/8, have the employee sign off on the notes. This places the onus on the note taker to write clear, legible and detailed notes. Write the date and time of the interview as well as who was present in the room during the interview; on Page 8/8, collect all documents from the investigation and organize it for filing in an appropriate, secure and confidential location.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated on a specified date and time, resident #014 reported to the Social Worker the resident had requested to be toileted and was not toileted for approximately four hours by PSW #135. The CIR was amended eight days later and indicated the investigation revealed that the incident actually occurred three days before the CIR was submitted, involved PSW #134 and the resident was not toileted for two hours. The CIR indicated the resident was upset and crying as a result of the incident. The CIR indicated the allegation was unfounded.

Review of the progress notes of resident #014 had no documented evidence of the incident that occurred on the specified date and time until three days later when a progress note was completed by the Social Worker (SW). The SW indicated they were

notified of a verbal complaint by resident #014, the resident was visibly upset and crying. The SW indicated the resident also reported the staff were not treating the resident with respect and dignity and requested to be relocated. The SW indicated the DOC, Administrator and RCAM were notified of resident's concerns.

Review of the staff schedule indicated PSW #134 continued to provide resident care on four specified dates prior to the initiation of the investigation.

Review of the licensee's investigation and interview of staff indicated resident #014 reported the allegation to the Social Worker two days after the incident occurred and the resident requested to be relocated. The resident informed the Social Worker the allegation was also reported to the night RN (RN #167) the same day the incident occurred. The Social Worker emailed the allegation to the DOC and did not call the on-call manager/supervisor as per the licensee's policy. The investigation notes were completed by the DOC and were not signed by the staff. The notes indicated PSW #134 and #135 were interviewed eight days after the incident was reported and continuing to provide care to residents on specified dates. PSW #134 reported they were working short staffed when the incident occurred and had to wait for approximately two hours for PSW #135 to provide assistance with toileting and the resident was upset. PSW #134 indicated the incident was reported to the charge nurse the same time the incident occurred. The licensee's investigation indicated no other staff were interviewed regarding the allegation (other PSW's, RPN and the RN that worked when the incident occurred). The DOC indicated the SDM was notified of the outcome of the investigation eight days later (when the investigation was started) and determined the allegation was unfounded. The DOC confirmed there was no investigation into the other allegations reported to the Social Worker by the resident and request to be relocated.

Interview with DOC and Administrator by Inspector #111 indicated the expectation of all staff, including managers is to immediately assess the resident, provide emotional support as needed, registered staff to document the incident and all managers/supervisors to utilize the investigation toolkit for completing all investigations. They both indicated this policy was not complied with related to this allegation of staff to resident improper care, despite determining the allegation was unfounded (111).

B.Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for an improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm that

occurred seven days prior at a specified time. The CIR indicated PSW #101 provided care to resident #015, put the resident in bed and noticed an injury to a specified area on the resident but did not report the injury. PSW #145 and RPN #149 observed the injury to a specified area. RPN #149 questioned PSW #101 regarding the injury to determine cause and the PSW reported the injury was noted when after providing care but unknown cause. RN #150 and the SDM were notified.

Interview with PSW #101 indicated the PSW was relieved of duty the same day the injury was noted to resident #015. The PSW indicated the DOC questioned the PSW the following day. The PSW indicated she/he then continued to provide care to resident #015 on three separate dates until the DOC changed the work assignment which would not include resident #015.

During an interview with the DOC, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation. A later interview with the DOC, she indicated that the investigation into the incident was determined to be not founded. The DOC indicated no awareness that PSW #101 continued to provide care to resident #015 that her instruction to RPN #149 were to change the PSW's work assignment. The DOC indicated the PSW involved with the incident should not have continued to provide care to resident #015. The DOC indicated that she became aware of the incident the next day and the incident should have been immediately reported to the Director when RN #150 became aware of the incident.(570)

Review of the licensee's investigation notes provided to Inspector #570 included written notes only. The written notes had no date and time identified to indicate when the interview took place and there were no employee signature on the notes.

During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations (#570).

C. Related to Log #005854-17:

A critical incident report (CIR) was received by the Director on a specified date for an

alleged staff to resident abuse. As per CIR notes, a family member of a co-resident reported a PSW was providing improper care to resident #004. The CIR indicated the allegation was determined to be unfounded. The CIR was completed by the Extendicare Long-Term Care consultant.

Review of the licensee's investigation contained a Client Feedback Log that indicated the investigation was completed on a specified date and concluded that the allegation of abuse was unfounded. There was no other documents from the investigation (i.e. interviews/statements).

Interview with the Extendicare Long-Term Care consultant by Inspector #570 indicated that she could not locate the investigation notes and that all records pertaining to the investigation should have been documented and kept in a secure place (570).

D. Related to Log # 018204-17:

A critical incident report (CIR) was submitted to the Director for an alleged resident to resident abuse incident that occurred on a specified date and time. The CIR indicated resident #012 was abusive towards resident #013.

Review of the licensee's investigation notes provided to Inspector #570 included a one page written note. The written note had no date and no time identified to indicate when the interview took place. Further, there was no employee signature on the note.

During an interview with the DOC by Inspector #570, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation.
During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations.(#570).

A Compliance order was warranted as the Licensee has had ongoing non-compliance with ensuring the policy to promote zero tolerance of abuse and neglect of residents, which includes investigations are to be completed immediately and appropriate actions

are taken, and allegations or suspicions are immediately reported to the Director. In addition, the licensee's failure to immediately report/investigate and take appropriate actions, increases the severity of harm to the residents. The licensee was issued LTCHA, 2007, s.20(1) on the following dates: a Written Notification (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on January 15, 2016; a (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on November 16, 2015 during the RQI inspection (#2015_365194_0028) and was complied with on August 5, 2016; a (WN) under the (CO) for LTCHA, 2007, s.19 (1) on January 16, 2017 during the RQI inspection (#2016_360111_0001). [s. 20. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:(i) Abuse of a resident by anyone and to ensure the results of the abuse or neglect investigation were reported to the Director.

Related to log # 009329-17 & #008920-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse. The CIR indicated resident #009 reported that resident #010 had been inappropriate towards the resident on a specified date. Resident #009 had also submitted a written complaint to the DOC two days after the incident occurred and indicated there had been ongoing incidents over the last four months. The CIR was completed by the Extendicare Consultant (acting DOC in place at time of incidents). The CIR was updated nine days later and indicated a response letter was provided to the resident but did not indicate the outcome of the licensee's investigation.

Review of the progress notes of resident #009 & resident #010, and the licensee's investigation indicated RPN #142 was notified of the allegation of resident to resident

abuse by resident #010 towards resident #009 on a specified date and time by resident #009. The following day, resident #009 reported the allegation a second time to a recreation aide. Resident #009 then submitted a written complaint to the acting DOC regarding the incident and previous abuse towards resident #009 by resident #010.

Review of the progress notes for resident #009 and #010 over a five month period indicated there were five additional incidents of alleged abuse by resident #010 toward resident #009.

Interview with resident #009 by Inspector #111 indicated she/he immediately reported the allegation of resident to resident abuse to RPN #142 after the incident occurred. The resident indicated no action was being taken, the resident was frustrated with resident #010 ongoing abuse, so two days later, the resident wrote a complaint letter to the home and the Director.

Interview with RPN #142 by Inspector #111 indicated on a specified date and time, resident #009 approached the RPN and reported that resident #010 had been abusive towards the resident and was upset. The RPN indicated she/he did not report the allegation because the incident was unwitnessed. The RPN indicated the incident was documented.

Interview with DOC and Administrator by Inspector #111 indicated the expectation of all staff, including managers is to immediately assess the resident, provide emotional support as needed, registered staff to document the incident and all managers/supervisors to utilize the investigation toolkit for completing all investigations. They both indicated this policy was not complied with related to this allegation of staff to resident improper care, despite determining the allegation was unfounded (111). Interview with the acting DOC (who was in place at time of allegations) by Inspector #111 indicated she became aware of the allegation of resident to resident abuse between resident #009 and resident #010 when she received the written compliant (two days after the incident was reported). The acting DOC indicated she submitted a written response to resident #009 which indicated an investigation was completed into each allegation and measures were put in place to address the concerns. The acting DOC indicated she initiated the investigation when she received the written complaint but could not provide the investigation into any of the alleged abuse incidents. The acting DOC was only able to provide an interview with RPN #142. The acting DOC indicated no other investigation was completed despite indicating such in the response letter to resident #009. In addition, the allegations of resident to resident abuse that occurred on four other

separate dates were not investigated.

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (ii) Neglect of a resident by the licensee or staff and that appropriate action was taken in response to the incident.

Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect. The CIR indicated on a specified date, resident #014 reported the allegation of staff to resident neglect by PSW #135 to the Social Worker. The CIR was amended eight days later, indicated as a result of the investigation, the incident actually occurred two days earlier than initial date provided and involved a different PSW (PSW #134). The CIR also indicated as a result of the investigation, the length of time of the neglect was shorter than initially indicated. The CIR indicated the resident was upset as a result of the incident. The CIR indicated the investigation concluded the allegation was unfounded.

Interview with resident #014 by Inspector #111 indicated the resident was still upset regarding the incident and felt the home took no actions to prevent a recurrence. The resident indicated the night RN was notified of the allegation the same day the incident occurred.

Review of the licensee's investigation and interview of staff indicated resident #014 reported the allegation to the Social Worker two days after the incident occurred and the resident requested to be relocated. The resident informed the Social Worker the allegation was also reported to the night RN (RN #167) the same day the incident occurred. The Social Worker emailed the allegation to the DOC and did not call the on-call manager/supervisor as per the licensee's policy. The investigation notes were completed by the DOC and were not signed by the staff. The notes indicated PSW #134 and #135 were interviewed eight days after the incident was reported and continuing to provide care to residents on specified dates. PSW #134 reported they were working short staffed when the incident occurred and had to wait for approximately two hours for PSW #135 to provide assistance with toileting and the resident was upset. PSW #134 indicated the incident was reported to the charge nurse the same time the incident occurred. The licensee's investigation indicated no other staff were interviewed regarding the allegation (other PSW's, RPN and the RN that worked when the incident

occurred). The DOC indicated the SDM was notified of the outcome of the investigation eight days later (when the investigation was started) and determined the allegation was unfounded. The DOC confirmed there was no investigation into the other allegations reported to the Social Worker by the resident and request to be relocated.

Interview with the DOC by Inspector #111 indicated she received an email regarding the allegation from the Social Worker the following day (three days after the incident). The DOC indicated that was when she began the investigation into the allegation. The DOC indicated the resident was interviewed, informed the DOC the allegation was reported to the RPN the day after the incident occurred. The DOC indicated she could not recall which RPN the resident reported the incident to and she did not speak to either the RPN or RN #167. The DOC indicated she did not investigate the other allegations of staff to resident abuse and request to be relocated. The DOC indicated the investigation was determined to be unfounded because the resident was not intentionally neglected. The DOC indicated actions taken to prevent a recurrence was she spoke to the two PSW's (PSW #134 & #135) at time of investigation to remind them of the resident's toileting requirements.

3. Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for neglect of a resident that resulted in harm or a risk of harm. The CIR indicated on a specified date and time, after PSW #101 provided care to resident #015 the PSW noted an injury to a specified area on the resident but did not report the injury. The resident left the room and PSW #145 and RPN #149 noticed the injury to the resident. RPN #149 questioned PSW #101 regarding the injury and indicated the injury was noted during care but unknown cause. RN #150 and the SDM were notified.

Interview with RN #150 by Inspector #570, indicated a message was left for the DOC regarding the incident and PSW #101 was immediately relieved of duty after the incident.

Interview with PSW #101 by Inspector #570 indicated the PSW was immediately relieved of duty after the incident and the DOC spoke to the PSW regarding the incident the following day. The PSW indicated he/she continued to provide care to resident #015 for three days after the incident until the DOC reassigned the PSW.

During an interview with the DOC by Inspector #570, she indicated that the investigation into the incident was completed eight days later and the outcome of the investigation was

unfounded. The DOC indicated no awareness that PSW #101 continued to provide care to resident #015 and her instruction to RPN #149 were to change the PSW's work assignment. The DOC indicated that the PSW involved with the incident should not have continued to provide care to resident #015.

The licensee has failed to take appropriate actions when the accused PSW #101 continued to provide care to resident #015 while the investigation was being completed (#570). [s. 23. (1) (a)]

4. Related to Log # 021111-17:

A complaint was received on a specified date regarding an allegation of resident to resident abuse that occurred on a specified date involving resident #036 towards resident #035. A Critical Incident Report (CIR) was also submitted to the Director on a specified date for the same allegation.

Review of progress notes for resident #035 indicated on a specified date, resident #036 was physically abusive to resident #035 resulting in an injury to a specified area on resident #035.

Review of progress notes for resident #036 indicated one to one monitoring was put in place on two consecutive shifts for a five day period after the incident. Two days after the one to one was completed, resident #036 was demonstrating responsive behaviours towards another resident.

Interview with RN #109 (charge nurse where both residents #035 and #036 reside) by Inspector #570, indicated the DOC was notified the day after the incident occurred and requested one to one intervention be put in place as resident #036 remained at risk of causing injury to other residents. RN #109 further indicated, the one to one intervention did not start until two days after the incident occurred and was supposed to be in place for three additional days but due to staff shortages, was unable to.

Inspector #570 interviewed the Director of Care (DOC) regarding appropriate actions taken following the incident of alleged resident to resident abuse involving residents #035 and #036, the DOC confirmed to the inspector that the one to one intervention did not start for resident #036 until two days following the incident. The DOC indicated to Inspector #570 that resident #036 demonstrated responsive behaviours towards another resident when the resident was supposed to have one to one intervention in place. The

DOC further indicated resident #036 was transferred to hospital for assessment related to responsive behaviours eight days after the incident occurred.

The licensee failed to take appropriate actions in response to the allegation of resident to resident physical abuse when the one to one interventions for resident #036 did not start until two days following the incident. (#570). [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone and to ensure the results of the abuse or neglect investigation were reported to the Director. (ii) Neglect of a resident by the licensee or staff and that appropriate action was taken in response to the incident., to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to log # 009329-17 & #008920-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse.

Review of the progress notes of resident #009 and resident #010 indicated RPN #142 was notified of the allegation of resident to resident abuse by resident #010 towards resident #009 on a specified date and time by resident #009. The progress notes for resident #009 and #010 over a five month period in 2017 also indicated there were four additional incidents of alleged abuse by resident #010 toward resident #009 and were not reported to the Director.

Interview with BSO RPN #171 and BSO PSW #134 by Inspector #111 both indicated the above reported incidents were reported to the RN working that day because they were contacted by the RN's to complete a referral for resident #010

Interview with RPN #142 by Inspector #111 indicated on a specified date and time, resident #009 reported that resident #010 was abusive towards the resident and was upset. The RPN indicated the incident was not immediately reported to the RN but reported the incident to the RN at shift change.

The verbal complaint by resident #009 regarding alleged resident to resident abuse was not reported to the Director until two days later. In addition, four additional allegations of resident to resident abuse were never reported to the Director. [s. 24. (1)]

2. Re: Log # 017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect. The CIR was amended seven days later and indicated

the incident occurred two days before the initial reported date, at a specified date and time, when resident #014 requested to be toileted and was not provided assistance for a specified period of time by PSW #134. The CIR indicated the resident was upset as a result of the incident.

Interview with DOC and the resident, and review of the licensee's investigation by Inspector #111, confirmed the incident occurred on a specified date and time. The resident reported the incident to RN #167 later the same evening when the incident occurred. The DOC was unable to indicate why the Director was also not made aware of the allegation the following day when the Social Worker was made aware of the allegation.

Interview with PSW #134 & #135 by Inspector #111, both indicated the charge nurse and RN #167 who worked on day the incident occurred was also made aware of the incident. Therefore, RN #167 and the charge nurse were aware of the allegation but did not immediately report the allegation to the Director. [s. 24. (1)]

3. Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for an improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm that occurred on a specified date and time. RN #150 was notified.

Interview with RN #150 indicated a message was left for the DOC and should have been immediately reported to the Director.
During an interview with the DOC, she indicated that she became aware of the incident the next day. The DOC indicated the incident should have been immediately reported to the Director when the evening supervisor RN #150 became aware of the incident.

Review of the CIR notes and interview of staff indicated the Director was notified of the incident seven days after the incident occurred (#570). [s. 24. (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 a person who has reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: 1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure the behavioural triggers had been identified for resident #010 demonstrating responsive behaviours of a sexual nature where possible, and strategies were developed and implemented to respond to the resident demonstrating responsive behaviours of a sexual nature.

Related to Log #008920-17 & #009329-17:

Review of the health record for resident #010 indicated the resident was diagnosed with

cognitive impairment and was independently mobile in a mobility aide. Review of the health record for resident #009 indicated the resident was cognitively well and independently mobile with a mobility aide
Review of the health record for resident #019 indicated the resident was cognitively impaired and also used a mobility aide.

Review of the progress notes for resident # 009, #010 and #019 over a three month period in 2017 indicated there were eight incidents of responsive behaviours of a sexual nature demonstrated by resident #010 towards two residents (resident #009 & #019) and one incident towards resident #020.

Interview with RPN #171 by Inspector #111 indicated the incident that occurred on a specified date involved resident #010 towards resident #009. The RPN also indicated the incident that occurred on another specified date, there was two incidents of responsive behaviours of a sexual nature made by resident #010 towards resident #009 and resident #019.
Interview with RPN #127 by Inspector #111 indicated the incident that occurred on another specified date involved resident #010 towards resident #009.

Interview with BSO/ PSW #134 by Inspector #111 indicated resident #010 was referred to BSO on a specified date for demonstrating responsive behaviours of a sexual nature demonstrated towards resident #009. The BSO/PSW indicated resident #010 was then discontinued from BSO program on a specified date as there were no further documented incidents. The BSO indicated resident #010 demonstrated the responsive behaviour towards resident #009 and resident #019. The BSO/PSW indicated on a specified date, resident #010 was again seen demonstrating responsive behaviour of a sexual nature and was put back on the BSO program the same day. The BSO indicated the physician was contacted and new medications were ordered. The BSO indicated the resident was discontinued from the BSO program again two months later, as staff had not reported or documented any further responsive behaviours and one specified intervention used appeared to be effective. The BSO/PSW indicated two days later, RCAM #130 reported resident #010 was again demonstrating responsive behaviours of a sexual nature towards another resident and BSO was "frustrated" because there was no documentation regarding the incident.

Interview with RCAM #130 by Inspector #111, indicated on a specified date, RPN #166 had reported to the RCAM that resident #010 was observed demonstrating responsive behaviour of a sexual nature towards resident #020 and directed the RPN to document

the incident. The RCAM indicated the incident was reported to the BSO/PSW #134.

Review of the 24 hour unit report forms for a specified month in 2017 had one note indicating resident #010 "behaviour still present" and BSO discontinued".

Review of the Behaviour Assessment Tool (BAT) (completed on a specified date) indicated the resident demonstrated multiple responsive behaviours of a sexual nature and the trigger was unknown. Interventions included: keeping resident away from co-resident is not always possible, resident is on close monitoring (every 30 minutes), redirect resident away from unspecified residents, spend 1:1 time with residents, invite resident to programs and have resident visit more often with spouse.

Review of the "Increased Observation Forms" (monitoring) indicated the resident was inconsistently placed on every fifteen minute and/or every half hour monitoring on five separate dates in one specified month, and on three separate dates on the following month in 2017.

Review of the written plan of care for resident #010 indicated the resident displayed responsive behaviours of a sexual nature. Interventions included: allow to talk with spouse on the phone, ensure is at nursing station where staff can easily see the resident at all times when not in bed, no identifiable triggers, Registered staff to administer medication and monitor for drowsiness, when inappropriate responsive behaviour is demonstrated toward unspecified co-resident, monitor and provide activity.

The written plan of care for resident #010 had no triggers identified for responsive behaviours of a sexual nature. The strategies used were not clearly identified or inconsistently implemented, specifically with the frequency of the monitoring strategy, it was unclear in the written plan of care which specified residents were the recipient of the responsive behaviours (despite progress notes and staff interviews clearly indicating resident #009 and #019 were the recipients), the strategy of calls/visits with spouse was not clearly stated when this would occur and how, and what activities were to be provided. There were no other strategies identified related to documentation of responsive behaviours/referrals to BSO, physician, or psychogeriatric services, or when this was to occur, and to determine other strategies, where possible (111). [s. 53. (4) (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 behavioural triggers are identified for resident #010, and any other residents demonstrating responsive behaviours of a sexual nature where possible, and strategies are developed and implemented to respond to any residents demonstrating responsive behaviours of a sexual nature, to be implemented voluntarily.

WN #9: 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:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, subsection 73 (1) 2, review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. Subsection 71 (6) the licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m.

Related to intakes #017491-17, #006958-17 and #008774-17:

A review of the Resident's Council (RC) meeting minutes from March 20, April 4 and 17, 2017 indicated the following:
-on March 20, 2017, residents expressed that breakfast in the Cedar Unit dining room was always late, PSWs were too busy getting ready for the day and were not able to be in the dining room to feed residents and serve food. A response given to the residents on March 24, 2017, indicated that a plan had been developed to observe the nursing process in the morning to determine root causes for the late arrival.

-on April 4, 2017, there was no indication that Residents were notified of the change to the breakfast and morning snack times.
-on April 17, 2017, residents expressed that the new times for breakfast were not helping, staff were still late coming to the dining room, food was coming out cold and there was not enough time between breakfast and lunch. A response given to the residents on April 20, 2017, by Extendicare Operations Manager (former acting Administrator at time of incident), indicated that the home was trying the new breakfast time aiming at ensuring all residents get better service and will continue to monitor.

However, during review of the RC Meeting minutes for May 15, June 28, and August 21, 2017, residents continued to express to be unhappy with changes in the dining room and would like the breakfast time changed back to 0815 hours. Residents felt the service was too rushed and there was not enough time between breakfast and lunch.

Inspector #461 observed breakfast in the main dining room on August 22, 2017 and the meal started at 0845 hours. By 0945 hours, there were still a few residents eating in the dining room. On September 1, 2017, the meal service started at 0845 hours and ended at 1030 hours.

During separate interviews with the Nutrition Manger (NM) #114 and Program Director #126, both indicated the breakfast time was not reviewed with the Resident's Council prior to implementation on April 12, 2017. Program Director #126 indicated a town hall meeting was held with management and staff, and the following day residents were notified of the changes. The NM #144 provided a memo for staff dated April 12, 2017, indicating the breakfast meal service will be at 0845 hours and AM nourishment pass will be at 1030 hours.

Interview with the Extendicare Operations Manager (former acting Administrator) indicated to Inspector #571, was not able to provide any evidence of the review on the breakfast time change with the Resident's Council prior to implementation on April 12, 2017.

The licensee has failed to review the changes of breakfast time from 0815 to 0845 hours and morning snack from 1000 to 1030 hours was discussed with the Resident's Council prior to the implementation in the home on April 12, 2017. [s. 73. (1) 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 the Residents Council is informed of changes to meals times, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home

has been investigated, and resolved where possible, and a response is provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately:

A. Related to Log #019022-17:

A review of the progress notes for resident #021 by Inspector #571, indicated on a specified date and time, the resident had verbally complained to staff regarding a missing mobility aide. The resident began demonstrating responsive behaviours related to their missing mobility aide. The RPN explained to the resident the mobility aide was still missing but that staff continued to look for the missing item. The only indication the verbal complaint received by resident #021 was investigated, was approximately two weeks later, when RCAM #109 documented requesting staff to search for the missing mobility aide and notified the SDM. There was no other investigation completed regarding the verbal compliant to determine how the residents mobility aide went missing.

The licensee failed to immediately investigate a verbal complaint made by resident #021 regarding a missing mobility aide (571).

B. Related to Log # 017491-17:

On a specified date, resident #012 indicated to Inspector #461, that a verbal complaint was provided to RPN #172 on a specified date, and was upset with how PSW #153 treated the resident. The resident indicated a verbal complaint was also provided to the DOC approximately one month later regarding personal care not provided by PSW #100 that occurred on the same day.

A review of resident #012 progress notes indicated on a specified date and time, PSW #153 approached RPN #172 indicating that resident #012 was upset at the PSW #153 related to personal care not provided in a timely manner and not treating the resident with respect. The progress note indicated that resident #012 requested to speak with the supervisor and RPN #172 notified RN #109. RN #109's progress notes indicated on the same day, the RN notified the resident that due to an emergency, the RN would speak to the resident later. When the RN returned to the resident's room later, the resident was not available. RN #109 re-approached the resident the following day, but the resident refused to speak to the RN. A review of the home's complaint log, indicated no documented

evidence the resident's complaint was logged.

During an interview with RN #109 by Inspector #461, the RN confirmed approaching the resident on a specified date, but the resident was not available and when RN went back to resident's room the following day, the resident refused to speak with RN. According to the RN, he/she thought the matter was settled as resident did not complain again, did not obtain any details about the verbal complaint and did not complete a complaint investigation form.

Review of the documented complaints indicated a complaint form was completed on a specified date (for a different complaint) for resident #012 after submitting a verbal complaint to the DOC at a specified time. The complaint indicated the resident was notified by RPN #155 that only PSW #100 was available on the unit for care and PSW #100 did not want to see the resident. The form was completed by the DOC and indicated she could not follow-up. The DOC interviewed RPN #155 and PSW #100 five days later. The complaint form stated the complaint was unfounded but there was no indication that the conclusion of the investigation had been reported to the resident. There was no indication of the verbal complaint received two months previously by RPN #172 regarding PSW#153.

Review of the Nursing staffing schedule indicated RPN #155 worked in the home and provided resident care on three separate dates prior to the initiation of the investigation. PSW #100 also worked in the home and provided care on two separate dates prior to the investigation. Therefore, the complaint investigation was not completed immediately.

During an interview with resident #012 on a specified date, by Inspector #461, the resident indicated a response had still not been received from the home related to the two verbal complaints regarding care by PSW #153 and PSW #100.

Interview with the Administrator by Inspector #461, indicated that staff are to follow the licensee policy related to complaints and complete the investigation complaint form, if the issue cannot be resolved within 24 hours. The Administrator indicated a response must also be given to the resident within 10 business days. The Administrator confirmed that resident #012's verbal complaints received did not have an investigation initiated or a response provided to the resident.

Interview with the DOC by Inspector #461, indicated no awareness related to initial complaint received by resident #012 and indicated she investigated the second verbal

complaint received involving resident #012 and PSW #100 but had not provided a response to resident #012.

The licensee failed to ensure that every verbal complaint was investigated (as the initial verbal complaint received was not investigated and resolved where possible), and a response was provided within 10 business days of the receipt of the complaint (as neither of resident #012's verbal complaints were provided a response). [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included: (a) the nature of each verbal or written complaint (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.

A. Re: log # 0035900-17:

A written complaint was received by the Licensee on a specified date from the family of resident #017. The written complaint was addressed to the home's previous administrator regarding services in the home.

Review of the Licensee's policy "Complaints and Customer Service" (RC-09-01-04) updated April 2017 indicated: under procedures, page 4 of 7, for Continuous Quality Improvement, 1. Maintain a record of all complaints and actions taken in the Compliant Log.

Review of the home's complaint log for 2017 had no documented evidence to indicate the written complaint was received from the family of resident #017 by the home or any actions taken (111).

B. Re: Log #019022-17:

A complaint was submitted to the Director regarding a missing wheelchair for resident #021. The SDM indicated that the SDM was notified on a specified date regarding the resident missing their mobility aide when the attachments did not fit. Resident #021's mobility aide had been repaired one month prior to the notification of the missing mobility aide and at that time noted the serial number on the invoice for the repair was different than the serial number of resident #021's current mobility aide. The SDM submitted a

written complaint to the licensee four months later, requesting that the licensee locate the missing mobility aide or replace the aide at the licensee's expense. A month after receiving the written complaint, the resident's mobility aide was still not located and the licensee had not replaced the missing mobility aide.

A review of the progress notes for resident #021 indicated that three weeks before the written complaint was received regarding the missing mobility aide, a care conference was held to discuss the resident's missing mobility aide. RCAM #109 indicated on that date a search would be completed and a response provided to the SDM. The following month, Behavioural Support Ontario (BSO), RPN #144 documented a referral was received for resident #021 related to the resident's aggressive behaviour in response to the missing mobility aide. RPN #144 informed the resident the missing mobility aide would be replaced by the licensee at that time.

In an Interview with Inspector #571, the DOC indicated that she reviewed the licensee's complaint log binder for 2017 and 2016 to see if a complaint was logged regarding resident #021's verbal and written complaint of a missing mobility aide and indicated there was no documented evidence that the resident's complaints were documented in the complaint log. [s. 101. (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 every written or verbal complaint made to the licensee or staff member concerning the care of a resident is immediately investigated and a response provided within 10 business days of receipt, to be implemented voluntarily.

WN #11: 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 :

The licensee failed to ensure that the treatment orders for resident #002 were provided to the resident as specified by the prescriber.

Re: Log #014980-17:

A review of the physician and Nurse Practitioner (NP) #178 orders for resident #002 over a three month period, review of the electronic medication administration records (eMAR) and electronic treatment administration records (eTAR) indicated the following:
-on a specified date and time, an order was received for a topical treatment to be applied to a specified area. The first dose of this treatment was not administered until two days later.
-three weeks later, an order was received for a different topical treatment to be applied to a specified area daily. This order did not appear on the eTAR until six days later and was not administered.
-on the same day, an additional order was received for a different topical treatment, also to be applied to the same specified area, but at a specified time. This order did not appear on eTAR until five days later and was not administered.
-twelve days later, an order was received for a specified treatment to a specified area, applied at a specified time and as needed until resolved. The routine order did not appear on the eTAR but only the as needed treatment order and the treatment was never signed for as administered.
-on the same day, an order was received for a second treatment to a specified area to occur daily, was to be reassessed in two weeks but not to stop the treatment. The treatment was stopped 14 days later on the eTAR and not reordered until eight days later.
-the following month, approximately four weeks later, the RCAM #109 indicated the previous order was re-clarified with the NP #178.

In an interview with Inspector #571, NP #178 indicated he/she was not contacted on the specified date for re-clarification of the order as indicated above, but was approached approximately two weeks after the order was written by RCAM #109. NP #178 also indicated that the nursing staff were not applying the topical treatment as ordered and noted this when he/she reassessed the resident (571).

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 treatments are provided to residents as specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #021 received assistance with a medical device used for communication.

Re: Log # 019022-17:

A complaint was submitted to the Director regarding resident #021 on a specified date. Resident #021 had a medical device and could not communicate without the application of the medical device. The Substitute Decision Maker(SDM) indicated that staff were not consistently applying the medical device.

A review of the care plan indicated that resident #021 had the medical device and indicated a specified shift, was to remove the device at a specified time and store the device in a specified location.

In an interview with Inspector #571, RPN #193 indicated that the RPN on a specified shift (different from the plan of care) was responsible for applying the medical device. In an interview with Inspector #571, RPN #116 showed Inspector #571 the medical device that was kept in the specified location. In an interview with Inspector #571, RPN #107 indicated that when he/she approached the resident to apply the medical device at a specified time (not according to the plan of care), the RPN was unable to apply the medical device due to the resident receiving care and had to give medication and forgot to go back to apply the device.

The licensee failed to ensure that resident #021 received assistance with a medical device (571).

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Related to log # 009329-17 & 008920-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged resident to resident abuse incident. The CIR indicated resident #009 reported to recreation staff #152 resident to resident abuse that occurred two days prior. The CIR indicated resident #009 also submitted a written complaint regarding the ongoing abuse by resident #010 towards the resident.

Review of the licensee's investigation and interview with staff indicated on a specified date, resident #009 reported to RPN #142 an allegation of resident to resident abuse by resident #010. Interview with RPN # 171 also indicated awareness of an allegation of abuse by resident #010 towards resident #009 that occurred approximately three months prior.

The CIR did not contain the names of RPN #142 or #171.

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:(ii) names of any staff members or

other persons who were present at or discovered the incident, and (iii) names of staff members who responded or are responding to the incident.

Related to Log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident. The CIR indicated resident #014 reported to the Social Worker the day before the resident had requested specified care and was not provided the specified care for a period of two hours by PSW #135. The CIR only identified the name of PSW #135.

Interview of staff, the resident and review of the Licensee's investigation indicated PSW #134 was directly involved in the allegation. The Social Worker, RPN #136, PSW #134 and RN #167 were also aware of the allegation and/or discovered the incident, and their names were not identified on the CIR (111).

3. Related to compliant Log # 021111-17:

A complaint was received on a specified date regarding an allegation of resident to resident abuse that occurred the day before involving resident #036 toward resident #035.

The Director of Care (DOC) also submitted a critical incident report (CIR) for the alleged resident to resident abuse incident that occurred at a specified time. The CIR indicated that resident #036 and resident #035 were involved in the incident and a PSW staff was present and/or discovered the incident.

Inspector #570 interviewed the administrative assistance staff #194, who indicated that he/she also witnessed the resident to resident abuse incident involving resident #036 towards resident #035, resident #035 was screaming, and both residents were separated by a PSW staff. Staff #194 further indicated he/she called the registered staff where both residents reside.

During an interview, the DOC indicated she spoke to the PSW who intervened but did not take any written statement from the PSW and did not recall the PSW’s name. The DOC further indicated that she was not aware that administrative assistant staff #194 witnessed the incident. The DOC further indicated that both RPNs on the residents' unit responded to the incident and assessed both residents and also notified the residents’

families. The DOC indicated she did not take any written statement from the RPNs and that she did not include the names of the RPNs and other staff involved in the CIR (#570).

Issued on this 24th 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) :	LYNDA BROWN (111), CRISTINA MONTOYA (461), PATRICIA MATA (571), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2017_643111_0013
Log No. / No de registre :	002637-17, 003590-17, 004285-17, 005741-17, 006958-17, 008774-17, 009287-17, 009329-17, 013929-17, 014938-17, 014980-17, 015397-17, 016984-17, 017491-17, 018204-17, 019022-17, 020744-17, 021111-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 8, 2017
Licensee / Titulaire de permis :	CVH (No.6) GP Inc. as general partner of CVH (No.6) LP c/o Southbridge Care Homes Inc., 766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Orchard Villa 1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6
	Lesreen Thomas

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 Administrator /
Nom de l'administratrice ou de l'administrateur :

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The Licensee shall prepare, submit and implement a corrective action plan to ensure there is adequate personal support services available on each unit, on each shift to meet the assessed needs of the residents. The plan is to especially ensure the residents are provided the opportunity and assistance to attend the breakfast meals, and receive assistance with their meals.

The plan should also clearly identify who will be responsible for implementing the planned actions and evaluating the effectiveness of these actions until the staffing problems linked to the program of personal support services for the home are resolved.

This corrective action plan is to be submitted via email to: OttawaSAO.MOH@ontario.ca to the attention of Lynda Brown, LTCH Nursing Inspector by November 15, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A. There were multiple complaints received through the Ministry of Health and Long-Term Care Action Line related to personal support staffing shortages impacting resident's care.

Interview with DOC by Inspector #111, indicated that the home is divided into 6 units (Aspen, Linden, Maple, Cedar, Birch and Pine). The DOC indicated Pine unit is the largest unit and has 49 residents.

Review of the Personal Support Workers (PSW) staffing schedule for a specified month in 2017 for a specified unit indicated there were a specified number of days when the unit was working short- staffed.

Interview with Nursing Administrative Assistant (Staff #120) by Inspector #111, indicated the home usually has the most short-staffing (with PSWs not at full compliment) on two specified units and usually occurs on specified shifts. Staff #120 indicated they are from sick call-ins or no-shows and usually occur over a four day period, resulting in the units working short-staffed (not working at full PSW compliment).

Interview with the Administrator by Inspector #111, indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff on two specified months in 2017 related to concerns with staff no-shows and attendance concerns (111).

B. Related to log #017491-17 & # 008774-17:

Review of the Resident Council meeting minutes for 2017 by Inspector #461 indicated in a specified month, the residents expressed concerns related to inconsistency in PSW staffing, residents not receiving the same PSW on a regular basis and happening for the past six months. There was also a concern that the breakfast for a specified unit in the dining room was always late, PSWs were still getting residents ready for the day and not able to be in the dining room to provide assistance with feeding/serving, was consistently short-staffed within the nursing department resulting in inconsistency with staff providing care to residents. Review of the Resident's Council meeting minutes for four specified months, indicated the residents were unhappy with changes in the dining room times and wanted the breakfast time changed back to 0815 hours. Residents indicated the service was too rushed and there was not enough time between breakfast and lunch.

On a specified date, Inspector #461 observed the breakfast meal service (scheduled to start at 0845 and to finish by 0930 hours) in all dining rooms. The large main dining room was divided by the various home areas: Linden, Birch, Maple, and Pine. Inspector #461 observed at 0845 hours, residents were being served fluids only and the actual meal service did not commence until 0900 hours. There were residents also noted to be missing from the dining room. The breakfast meal service was still occurring at 0945 hours.

Interview with RPN #127 and PSW #141 on a specified date by Inspector #461, indicated that a specified unit had been short-staffed for the past five days. Both staff indicated on this specific date they were also short-staffed (not at full PSWs compliment) which lead to residents arriving late for breakfast. PSW #141 indicated at 0900hours, there were six residents still waiting to be taken to the dining room for breakfast.

On a specified date, during separate interviews with the Nutrition Manager #114 and Program Director #126, by Inspector #461, both indicated the breakfast start time was changed from 0815 to 0845 hours on a specified date without input from the Resident's Council. The Nutrition Manager indicated the start of breakfast time was changed because PSWs did not have enough time to bring all the residents to the dining room for breakfast.

On a specified date, Inspector #461 observed the main dining room for breakfast and noted the following: at 0845 hours, staff were noted still bringing residents into the dining room for breakfast; at 0900 hours, a PSW reported that they were still waiting for 2 residents to arrive; at 0905 hours, approximately 30 residents were sitting at their tables with just their drinks and had not yet received the hot cereal or any other breakfast items. The residents were not offered hot cereal until approximately 0920 hours; at 0910 hours, table #7 had four residents seated, including resident #022. The resident asked the Inspector for hot cereal (as there was no staff to assist) and indicated the resident had been waiting for approximately 15 minutes. At the same table, only 1 out 4 residents had received their hot cereal; at 0920 hours, the Inspector noted one resident was waiting to be brought to the dining room for breakfast. The resident was brought to the dining room at 0925 hours. There were still several residents in main dining room (specifically on Birch and Pine unit) that were still having breakfast after 0930 hours.

Interview with the Operations Manager (former acting Administrator) by Inspector #571, indicated that breakfast time was changed from 0815 to 0845 hours because when breakfast was served at 0815 hours, three quarters of the residents were not in the dining room to begin the breakfast meal. The former interim Administrator indicated with change in meal time, the breakfast meal was now completed between 0915 and 0930 hours. The former interim Administrator confirmed that an evaluation of the time change had not been completed to determine if the meal time change had been effective.

On a specified date, Inspector #461 observed the main dining room for the breakfast meal, and noted the following where residents from a specified unit were located: at 0850 hours, the residents had not yet received their fluids and there were no PSWs available to assist with meal service; at 0905 hours, residents were still arriving to the dining room and at 0910 hours, PSW #168 from the Birch unit arrived to the dining room and starting serving the residents on this unit; at 0925 hours, all four PSWs from the Birch unit were now present in the dining room. At 0930 hours, resident #012 was provided the main course of breakfast. Resident #012 stated to the Inspector the meal service at breakfast "was late almost every day". At 0938 hours, resident #025 arrived to the dining room, PSW #124 indicated that resident usually comes to the dining room independently but needs reminders, because they were short a PSW staff, the resident was forgotten in their room. Resident #025 received the breakfast meal at 0942 hours. At 1000 hours, resident #026 was served the breakfast meal, despite being seated in the dining room since 0850 hours. At 1005 hours, PSW #168 had prepared food trays for residents on isolation (resident #027, #029, and #030). The PSW has also prepared a fourth tray for resident #032. The PSW reported to the Inspector that resident #032 normally came to the dining room but the PSW did not have time to get the resident up for breakfast. PSW #168 also indicated that being short-staffed greatly affected the care provided to residents in the morning. The breakfast meal service on this date did not conclude until 1030 hours. Inspector #461 noted the morning snack was to be served at 1030 hours and lunch provided at 1200 hours. The home was not providing adequate time between the breakfast and the lunch meal to promote healthy appetite and ensure adequate nutritional intake for residents.

During an interview with the Administrator by Inspector #461, indicated awareness of the residents getting to the dining room late for breakfast and therefore not leaving the dining room until after 0930 hours. The Administrator also indicated the breakfast time change was yet to be evaluated (461).

C. Related to log # 003590-17 & # 002637-17:

Interview with resident #017 by Inspector #111 indicated the regular PSW was away for a specified period of time and ever since then, the resident has had a new PSW every day. The resident also indicated the resident was supposed to have a shower and hair washed in the morning approximately a week ago, but the staff were too late getting to the resident due to PSW short-staffing. The resident indicated the shower was refused because of an appointment at that time and was upset.

Interview with PSW #147 by Inspector #111, indicated resident #017 has a shower two days per week. The PSW indicated the resident prefers to have the shower before breakfast but the staff cannot always provide the shower at that time. The PSW indicated the shower sometimes has to be later in the morning due to PSW short-staffing (PSW not working at full compliment) and the resident will then refuse (111).

D. Related to log # 017305-17:

A critical Incident Report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect. The CIR indicated resident #014 had reported a verbal complaint the resident was not toileted as requested two days prior for a period of two hours.

Review of the resident #014 health record, review of the licensee's investigation and interview of staff (PSW #134 & #135) by Inspector #111, indicated on a specified date and time, resident #014 had rang the call bell and requested assistance with toileting. Resident #014 required two staff assistance with a mechanical lift. PSW #134 indicated he/she would get assistance and the mechanical lift and return but did not return until approximately two hours later with PSW #135. The resident was incontinent, was upset and crying as a result. PSW #134 indicated that they were working short-staffed (PSW not working at full compliment) that evening and had to wait for PSW #135 to be able to assist with toileting (111).

E. Related to log # 014938-17:

An anonymous complaint was received by the Director regarding the home

always working short-staffed (PSWs not at full compliment), especially in the evenings, and on the unit with 49 residents.

Interview with PSW #140 on a specified unit by Inspector #111, on a specified date indicated the unit was working short-staffed today (PSW not at full compliment) and has worked short-staffed for the last five days in a row. The PSW reported to Inspector #461 that the staff were late getting residents to the dining room for breakfast (not until after 0900 hours) as a result. In an interview with PSW #140 on a specified date by Inspector #111 indicated the same specified unit has been short-staffed on a specified shift every day for last two weeks.

Interview with PSW #123 & #125 and RPN #121 on a different specified unit by Inspector #111 on a specified date, indicated they frequently work short- staffed, usually 3-4 times per week. The PSW's indicated they were working short-staffed again today. The PSW's indicated they were a half hour late getting the residents down to the dining room for lunch as a result. The PSW's indicated one PSW had to remain on the floor to assist with toileting during the meals so they only had 3 PSW's to assist with feeding 41 residents.

Interview with the Administrator by Inspector #111 indicated she identified the home was experiencing issues with PSW staffing related to a number of sick calls, no shows and vacancies. The Administrator indicated the home is working at recruiting staff to fill vacancies and disciplinary actions related to absenteeism. The Administrator indicated they also posted two memo's for staff in two specified months related to concerns with staff no-shows and attendance concerns.

The severity of this non-compliance indicated that there was potential for harm/risk as the organized personal support staffing was not meeting the needs of the residents, and the scope was a demonstrated pattern as there was two out of six resident units where the PSWs were noted not working at full compliment. This impacted the resident care by the following: resident #014 was not toileted as requested for a period of two hours, resulted in the resident being upset; several residents on two specified units were not receiving their breakfast meals in the dining room and/or within the designated meals times (despite the meal time being changed to a later time). Not providing adequate time between the breakfast, morning snack, and the lunch meal does not promote healthy appetite and ensure adequate nutritional intake for those residents; and resident

#017 who requested showers to be provided before breakfast to accommodate an appointment, was occasionally not receiving a shower on those days when PSWs were work short-staffed (111). (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2018

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Order / Ordre :

The licensee shall immediately reimburse all residents who were charged the $5.00 portering fee for advanced foot care since June 13, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are not charged for goods and services that they are required to provide using funding.

Related to Log #014980-17:

A review of the Family Council meeting minutes for a specified date, by Inspector #571 indicated that foot care was an unfunded service and in future, a charge of twenty five dollars would be charged to those residents and the service would be provided every eight weeks. The minutes indicated the service was optional and another provider could be chosen. Review of a memo, with a specified date, indicated that effective June 13, 2017, residents would be charged for foot care services as historically, the home provided the unfunded service at no charge but were no longer able to continue.

In an interview with Extendicare Operations Manager (former acting Administrator) by Inspector #571, clarified that the memo and Family Council meeting minutes were referring to advanced foot care only. The Operations

Manager indicated that the licensee was previously providing advanced foot care at no cost to the residents and since advanced foot care was an unfunded service, the licensee decided to hire an outside advanced foot care nurse to provide advanced foot care services to residents. The Operations Manager indicated the total advanced foot care charge was thirty five dollars which included: thirty dollar charge for the foot care nurse and five dollar charge that was used to pay a PSW (employee of the home) to porter the residents to a central location in the home for the foot care service.

In an interview by Inspector #571 with the Administrator, indicated that the advanced foot care was provided in each resident room rather than in a central location. The Administrator indicated, the advanced foot care service by an outside provider was a new process and the licensee was still working on the process.

The licensee provided a list to Inspector #571 that indicated 84 residents had been charged and paid for the 35 dollar advanced foot care, which included the five dollar portering charge, since June 13, 2017.

The licensee receives funding through the nursing and personal care envelope from the Ministry of Health and Long Term Care. Such funding would include portering of residents to all areas within the long term care home. Therefore, the five dollar charge for portering is prohibited (571). (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a corrective action plan to ensure:
1) All RCAMs, RNs and RPNs are retrained on the licensee's skin and wound program,
2) The clinically appropriate assessment tool (Bates-Jensen) is completed as per the Licensee's skin and wound Care Program,
3) The Wound Care Lead conducts wound care rounds, and quality improvement reviews as per the licensee's skin and wound care program, and promptly responds to referrals from the nursing staff with any new or changes in skin and wounds.
4) Referrals are completed to specialized wound services (ET Therapy) and are timely and effective,
5) Communication that occurs between nursing staff, the physician or Nurse Practitioner(i.e. RPN to RN, and RN to RCAMs), meaningful information is shared when residents are having a new, change or deterioration of any alteration in skin and/or wounds.
5) RPN's complete the wound surveillance records as per the Licensee's skin and wound care program.

The corrective action plan is to be submitted via email to: OttawaSAO.MOH@ontario.ca attention Lynda Brown, LTCH Nursing Inspector by November 15, 2017.

Grounds / Motifs :

1. The licensee failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was fully implemented in the home.

A review of the licensee's Skin and Wound Program: Prevention of Skin Breakdown (RC-23-01-01) and Wound Care Management policy (RC-23-01-02), last updated February 2017 indicated the program gives directions including the following:
- RC-23-01-01: to designate a Wound Care Lead to coordinate the program and work with the interdisciplinary team to ensure program implementation and effectiveness; conduct wound rounds and quality improvement reviews regularly. Appendix 1 directs the nurse to inform Wound Care Lead, Physician/Nurse Practitioner (NP) of any new and/or worsening skin breakdown and as need; complete surveillance as required.

-RC-23-01-02: the Nurse or Wound Care Lead to: promptly assess all residents exhibiting altered skin integrity on initial discovery; use a Bates Jensen Wound Assessment Tool for pressure ulcers/venous stasis or ulcer of any type; use an Impaired Skin Integrity Assessment Tool for all other skin impairments (i.e., skin tears, rashes, reddened areas, bruises); monitor resident skin condition with each dressing change, re-assess at minimum weekly; re-evaluation and documentation of treatment with creams and other medicated preparations should occur at minimum weekly; initiate one Bates-Jenson Wound Assessment for each open area/wound; complete the Bates-Jensen Assessment if condition worsening or not improving as expected, but at a minimum every seven days; photograph pressure ulcers and complex wounds as needed to track healing and assess treatment effectiveness;

Related to Log # 016984-17:

Resident #005 was admitted to the home with diagnoses that included alteration in tissue perfusion, history of skin breakdown and wounds to specified areas. The resident was hospitalized on two separate occasions related to wounds since admission. A review of the clinical health record over a seven month period, from the time of admission, indicated the following:
-the following month after admission, the resident's wounds were assessed by an Enterostomal Therapy (ET) Nurse and new treatments were ordered for wounds to specified areas.
-the following month, the dressings and the wounds, on specified areas, were noted to have a foul smell. A week later, moderate, foul smelling drainage was noted from specified wounds. A week later, a specified wound had a change in the amount and type of discharge. A week later, the resident was assessed by the ET Nurse and recommended a new treatment, and suggested antibiotics for specified wounds due to infection.
-the following month, resident was reassessed by the ET Nurse, the resident was sent to hospital due to skin related changes to specified areas and treated with antibiotics. The resident returned from hospital a month later and continued the antibiotic therapy. A week later, another wound to a specified area was noted to be deteriorating. A week later, dressing changes to specified wounds indicated excessive bleeding and the Physician was notified. The Physician discontinued specified treatments.
-two days later, a specified wound was noted to further deteriorate and was reported to the Resident Care Area Manager (RCAM). A referral was made to the Wound Care Lead.

-three days later, a Weekly Impaired Skin Integrity Assessment was completed and indicated the wound over one specified area had deteriorated further, and identified four other areas with altered skin integrity.
-three days later, a Bates-Jensen Assessment was completed and indicated the wound to a specified area had deteriorated further.
-a week later, the Weekly Impaired Skin Integrity Assessment indicated the wound to a specified area was larger and further deteriorated.
-a week later, a Bates-Jensen Assessment indicated the wound to a specified area was larger and the four other wounds to specified areas were also getting larger. There was also two additional wounds noted.
-a week later, all wounds were noted to have large amount of foul smelling drainage and the resident was crying out in pain. The Physician was contacted and the resident was transferred to hospital for assessment.

A review of the clinical health records for resident #005 indicated over a seven month period in 2017, the Bates-Jenson skin assessment was completed as follows:
-on a specified date, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed.
-the following month, two assessments were completed, one for multiple wounds to a specified area and one for multiple wounds to another specified area. The Inspector was unable to determine what the measurements were for which wounds and descriptions of the wounds due to multiple wounds listed. o
-two months later, one incomplete assessment was completed for a specified area which was lacking wound measurements.
-six days later, one assessment was completed for a specified area with multiple skin breakdown to specified areas.
-the following month, one assessment was completed for a specified area with specified measurements.
-the following month, one assessment was completed for five different specified areas with specified measurements. The specified areas measured larger than the previous month with additional areas.
-the following month, one assessment was completed for multiple wounds to two specified areas.
-six days later, one assessment was completed for two wounds to a specified area and one assessment for five wounds to another specified area.

In an interview with Inspector #571, RPN #117 indicated that resident #005 had returned from the hospital on a specified date with a wound to a specified area and described the wound. RPN # 117 indicated no awareness of requirement to complete weekly Bates-Jensen assessments for specified types of wounds. RPN #117 indicated the RCAM/Wound Care Lead (#130) was notified of the wound.

In an interview with Inspector #571, RCAM/Wound Care Lead (#130) indicated that resident #005 was admitted to the home with multiple wounds so he/she arranged to have an Enterostomal Therapy (ET) Nurse come in to assess resident #005's wounds monthly. The ET Nurse did not assess the resident in one specified month as the home was in outbreak. RCAM #130 indicated that he/she had just become aware that the Bates-Jensen wound assessments had to be completed for all wounds, not just pressure ulcers. RCAM #130 indicated that the Skin and Wound Program policy was new and that he/she is still learning about the Program. In addition, he/she indicated the nurses were to track all wounds on the wound tracking form but that the forms were not always completed. The RCAM indicated when a resident had a new, challenging or worsening wound, staff were to submit an electronic referral to the wound care lead but he/she was not always able follow up on the referrals right away. The RCAM indicated wounds were not photographed in the home.

There was no documented evidence to indicate the Bates-Jensen weekly skin assessment (the clinically appropriate assessment instrument) was completed 17 times during a five month period for resident #005's multiple wounds. The Bates-Jensen assessments were not completed weekly for each of the wounds that resident #005 had, it was not clear when the resident started to display signs and symptoms of a specified tissue alteration diagnosis and this diagnosis was not discovered until the NP completed a monthly assessment of the resident and sent to the hospital. Also, it was unclear what the status of resident #005's wounds were from week to the next week and exactly where the wounds were located, as the licensee was not ensuring that registered nursing staff were using a Bates-Jensen tool weekly for each wound.

There was no documented evidence that photographs were taken of any of resident #005's wounds. There was no documented evidence to indicate that the physician or Nurse Practitioner was notified when resident #005's wounds displayed signs and symptoms of infection on a specified date (wounds were noted to be foul smelling), until the ET Nurse completed the monthly wound

assessment approximately three weeks later and recommended antibiotics. There was no documented evidence to indicate that the physician or Nurse Practitioner was notified when resident #005's wounds were increasing in size (deteriorating). The licensee failed to ensure that their interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was implemented.

Since resident #005's admission to the home, resident #005 developed and/or had multiple, worsening wounds and included infection to her bilateral arms and legs that resulted in two hospitalizations. In addition, a wound over the left Achilles tendon deteriorated from 4 cm long by 3 cm wide on June 1, 2017, to 12cm by 7.5 cm with an exposed tendon on July 9, 2017. The licensee failed to ensure that correct documentation, assessment or follow-up was conducted as per their Skin and Wound Program. A Compliance Order was issued as a result under O. Reg. 79/10, s. 48 (1) 2., due to the severity and negative outcome towards resident #052. [s. 48. (1) 2.] (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2017

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

1) Ensure that resident #014 and #021 are provided with assistance and supervision with toileting according to the care set out in their plan of care; and assistance and supervision is provided to any other residents based on their assessed needs, related to toileting.

2) Develop and implement a monitoring tool to ensure that all residents, including resident #014 and #021, are provided with assistance and monitoring with toileting according to their assessed needs.

3) Ensure that supervision from nursing supervisors/managers is heightened, when the personal support staffing is not at full staffing levels, to ensure that all residents are provided with proper care, assistance and supervision with all care needs, according to the planned care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #021 as specified in the plan, related to toileting.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated two days before at a specified time, the resident was not toileted for a specified period of time.

Review of the written plan of care for resident #014 (in place at time of incident) under toileting/continence indicated: the resident was incontinent, wears an incontinence product, requires two staff assistance with mechanical lift and the resident to be reminded to use call bell when assistance is required.

Review of the licensee's investigation, review of resident #014's health record and interview of staff indicated: on a specified date and time, the resident had rang for assistance with toileting. PSW #134 responded to the call bell and informed the resident she/he would have to get the mechanical lift and a co-worker (PSW #135) to assist with toileting. The PSW indicated PSW #135 was unable to return to assist the resident for a specified period of time. The PSW returned to the resident approximately two hours later and the resident was upset as a result. PSW #134 indicated no other staff were asked to provide assistance with toileting despite two other PSW's working on the unit and indicated they were working short-staffed that evening as well (111).

B. Related to Log # 019022-17:

A review of the written care plan for resident #021 (at time of incident) indicated under toileting, an intervention (initiated prior to the incident) directing staff not to leave the resident unattended on the toilet. An intervention of an alarming device was also to be used to alert staff when the resident was going to the bathroom.

Review of the progress notes for resident #021 indicated that on a specified date and time, resident #021 was found sitting on the bathroom floor, with an injury to a specified area. The PSW reported the resident had been left on the toilet unattended by a staff member.

In an interview with Inspector #571, RPN #192 indicated resident #021 had history of multiple falls. The RPN indicated on a specified date, when resident #021 sustained the fall, the resident was left unattended on the toilet by a PSW.

On a specified date and time, Inspector #571 observed resident #021 sitting in a mobility aide in his/her room. The resident then proceeded to enter the bathroom and attempted to self-transfer to the toilet. The alarming device did not activate and the Inspector noted the alarming device was turned off.

In an interview with RPN #179 by Inspector #571, indicated that she/he has to

remind staff all the time to not turn off the alarming device.

The licensee failed to ensure that the care set out in the plan of care related to toileting was provided to the resident as specified in the plan, specifically, the alarming device and supervision with toileting.

A Compliance Order was warranted as the Licensee has had ongoing non-compliance with ensuring resident's plan of care were provided to residents, as specified in their plan, related to LTCHA, 2007, s.6(7). The Licensee was issued a Written Notification (WN) for s.6(7) under Compliance Order (CO)#002 for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on November 30, 2015. LTCHA, 2007, s.6(7) was issued as a WN on June 8, 2015 during a critical incident inspection (#2015_293554_0009). LTCHA, 2007, s.6(7) was issued as a (CO) on July 5, 2016 during the RQI inspection (#2016_327570_0014) and was returned to compliance on January 9, 2017. The Licensee was issued a (WN) for LTCHA, 2007, s.6(7) on October 4, 2016 during a complaint inspection (#2016_327570_0022). The Licensee was also issued a (WN) for s.6(7) under Compliance Order (CO)#003 for LTCHA, 2007, s.19 (1) on January 16, 2017 during a RQI inspection (#2017_360111_0001) with a compliance date of June 30, 2017. [s. 6. (7)] (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The Licensee shall:
1) Ensure that any staff member who witnesses, suspects or receives an allegations of abuse and/or neglect of a resident by anyone, immediately reports the incident to the Director with the support of their immediate supervisor.
2) Ensure when the Nursing Supervisors/Managers/Administrator/DOC/or delegate are made aware of an alleged, suspected or witnessed incident of abuse and/or neglect, they immediately investigate the incident(s).
3) Ensure that all of the investigations are completed as per the home's Prevention of Abuse and Neglect policy, specifically,
a) residents are assessed and actions are taken to protect the residents, and this is documented in the residents health record,
b) the investigation toolkit is used, to ensure the investigation is completed thoroughly
c) the evidence linked to the investigation is kept in a consistent, secure location and the outcome of the investigation is clearly documented.
d) immediate actions are taken with those involved in the allegations, as per the licensee's policy.

Grounds / Motifs :

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

Review of the Licensee's policy "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences" (updated April 2017):
-(RC-02-01-01), page 3/8, promptly investigate resident to resident altercations,

complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.
-(RC-02-01-02), anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. Staff must complete an internal incident report and notify their supervisor. The Nurse would then call the Manager on-call immediately upon suspecting or becoming aware of abuse or neglect of a resident.Management will promptly and objectively report all incidents to external regulatory authorities.On page 2/5, the Administrator has the authority to place an employee on Leave of Absence with pay, pending the results of the investigation. On page 3/5, all staff are to ensure the safety of and provide support to the abuse victim(s) through completion of full assessments, a determination of residents needs and a documentation plan to meet those needs. Other specialized supports to resident/families involved in the alleged incident (e.g. social work counselling). In case of physical and/or sexual abuse, accurate detailed descriptions of injuries/condition are documented in the resident chart.
- (RC-02-01-03), page 3/5, the Administrator or designate, immediately advise the employee that they are being removed from the work schedule, with pay, pending the investigation, the investigating manager/supervisor will: fully investigate the incidents in keeping with the step as outlined in the investigation toolkit; Under Appendix 2, page 2/8, collect employee statements; page 4/8, prior to the start of your interviews, create a list of all witnesses who have direct or indirect knowledge of the incidents, take note to add them to you interview list; page 5/8, have the employee sign off on the notes. This places the onus on the note taker to write clear, legible and detailed notes. Write the date and time of the interview as well as who was present in the room during the interview; on Page 8/8, collect all documents from the investigation and organize it for filing in an appropriate, secure and confidential location.

A. Related to log #017305-17:

A critical incident report (CIR) was submitted to the Director on a specified date for an alleged staff to resident neglect incident towards resident #014. The CIR indicated on a specified date and time, resident #014 reported to the Social Worker the resident had requested to be toileted and was not toileted for approximately four hours by PSW #135. The CIR was amended eight days later and indicated the investigation revealed that the incident actually occurred three days before the CIR was submitted, involved PSW #134 and the resident was not toileted for two hours. The CIR indicated the resident was upset and crying

as a result of the incident. The CIR indicated the allegation was unfounded.

Review of the progress notes of resident #014 had no documented evidence of the incident that occurred on the specified date and time until three days later when a progress note was completed by the Social Worker (SW). The SW indicated they were notified of a verbal complaint by resident #014, the resident was visibly upset and crying. The SW indicated the resident also reported the staff were not treating the resident with respect and dignity and requested to be relocated. The SW indicated the DOC, Administrator and RCAM were notified of resident's concerns.

Review of the staff schedule indicated PSW #134 continued to provide resident care on four specified dates prior to the initiation of the investigation.

Review of the licensee's investigation and interview of staff indicated resident #014 reported the allegation to the Social Worker two days after the incident occurred and the resident requested to be relocated. The resident informed the Social Worker the allegation was also reported to the night RN (RN #167) the same day the incident occurred. The Social Worker emailed the allegation to the DOC and did not call the on-call manager/supervisor as per the licensee's policy. The investigation notes were completed by the DOC and were not signed by the staff. The notes indicated PSW #134 and #135 were interviewed eight days after the incident was reported and continuing to provide care to residents on specified dates. PSW #134 reported they were working short staffed when the incident occurred and had to wait for approximately two hours for PSW #135 to provide assistance with toileting and the resident was upset. PSW #134 indicated the incident was reported to the charge nurse the same time the incident occurred. The licensee's investigation indicated no other staff were interviewed regarding the allegation (other PSW's, RPN and the RN that worked when the incident occurred). The DOC indicated the SDM was notified of the outcome of the investigation eight days later (when the investigation was started) and determined the allegation was unfounded. The DOC confirmed there was no investigation into the other allegations reported to the Social Worker by the resident and request to be relocated.

Interview with DOC and Administrator by Inspector #111 indicated the expectation of all staff, including managers is to immediately assess the resident, provide emotional support as needed, registered staff to document the incident and all managers/supervisors to utilize the investigation toolkit for

completing all investigations. They both indicated this policy was not complied with related to this allegation of staff to resident improper care, despite determining the allegation was unfounded (111).

B.Related to Log # 016955-17:

A critical incident report (CIR) was submitted on a specified date for an improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm that occurred seven days prior at a specified time. The CIR indicated PSW #101 provided care to resident #015, put the resident in bed and noticed an injury to a specified area on the resident but did not report the injury. PSW #145 and RPN #149 observed the injury to a specified area. RPN #149 questioned PSW #101 regarding the injury to determine cause and the PSW reported the injury was noted when after providing care but unknown cause. RN #150 and the SDM were notified.

Interview with PSW #101 indicated the PSW was relieved of duty the same day the injury was noted to resident #015. The PSW indicated the DOC questioned the PSW the following day. The PSW indicated she/he then continued to provide care to resident #015 on three separate dates until the DOC changed the work assignment which would not include resident #015.

During an interview with the DOC, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation. A later interview with the DOC, she indicated that the investigation into the incident was determined to be not founded. The DOC indicated no awareness that PSW #101 continued to provide care to resident #015 that her instruction to RPN #149 were to change the PSW's work assignment. The DOC indicated the PSW involved with the incident should not have continued to provide care to resident #015. The DOC indicated that she became aware of the incident the next day and the incident should have been immediately reported to the Director when RN #150 became aware of the incident.(570)

Review of the licensee's investigation notes provided to Inspector #570 included written notes only. The written notes had no date and time identified to indicate when the interview took place and there were no employee signature on the notes.

During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations (#570).

C. Related to Log #005854-17:

A critical incident report (CIR) was received by the Director on a specified date for an alleged staff to resident abuse. As per CIR notes, a family member of a co-resident reported a PSW was providing improper care to resident #004. The CIR indicated the allegation was determined to be unfounded. The CIR was completed by the Extendicare Long-Term Care consultant.

Review of the licensee's investigation contained a Client Feedback Log that indicated the investigation was completed on a specified date and concluded that the allegation of abuse was unfounded. There was no other documents from the investigation (i.e. interviews/statements).

Interview with the Extendicare Long-Term Care consultant by Inspector #570 indicated that she could not locate the investigation notes and that all records pertaining to the investigation should have been documented and kept in a secure place (570).

D. Related to Log # 018204-17:

A critical incident report (CIR) was submitted to the Director for an alleged resident to resident abuse incident that occurred on a specified date and time. The CIR indicated resident #012 was abusive towards resident #013.

Review of the licensee's investigation notes provided to Inspector #570 included a one page written note. The written note had no date and no time identified to indicate when the interview took place. Further, there was no employee signature on the note.

During an interview with the DOC by Inspector #570, she indicated that when conducted interviews she took notes in a note book. The DOC further indicated, she should have used the Complaint Investigation Form when conducting and documenting the interviews as part of the investigation.
During an interview with the Administrator by Inspector #570, she indicated that it is the expectation that managers should use the designated investigation forms when conducting investigations related to complaints and abuse allegations.

The licensee has failed to comply with the written policy that promotes zero tolerance of abuse and neglect of residents specific to conducting investigations. (#570).

A Compliance order was warranted as the Licensee has had ongoing non-compliance with ensuring the policy to promote zero tolerance of abuse and neglect of residents, which includes investigations are to be completed immediately and appropriate actions are taken, and allegations or suspicions are immediately reported to the Director. In addition, the licensee's failure to immediately report/investigate and take appropriate actions, increases the severity of harm to the residents. The licensee was issued LTCHA, 2007, s.20(1) on the following dates: a Written Notification (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on June 3, 2015 during a critical incident inspection (#2015_360111_0014) and was returned to compliance on January 15, 2016; a (WN) under Compliance Order (CO) for LTCHA, 2007, s.19 (1) on November 16, 2015 during the RQI inspection (#2015_365194_0028) and was complied with on August 5, 2016; a (WN) under the (CO) for LTCHA, 2007, s.19 (1) on January 16, 2017 during the RQI inspection (#2016_360111_0001). [s. 20. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail, 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 8th day of November, 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 : LYNDA BROWN

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