Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d’inspection 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d’Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jun 28, 2017	2017_591623_0009	008232-17	Resident Quality Inspection

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

SARAH GILLIS (623), BAIYE OROCK (624), CRISTINA MONTOYA (461), DENISE BROWN (626), SAMI JAROUR (570)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): May 31, June 1, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 2017

The following logs were inspected;
029698-16 - Complaint related to medication administration
005782-17 - Complaint related to alleged improper care, verbal & emotional abuse staff to resident.
005817-17 - Complaint related to a fall resulting in injury.
001590-17 - Complaint related to staffing levels and maintenance of the home.
032609-16 & 035045-16- Critical Incident related to allegation of staff to resident physical abuse
032618-16, 003357-17, 005385-17- Critical Incident related to resident to resident physical abuse
035166-16 - Critical Incident related to resident to resident alleged verbal and physical abuse.
006631-17 - Critical incident related to improper transfer resulting in injury.
011244-17 - Critical incident related to a fall resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (DOC), Nutritional Care Manager, Registered Dietitians (RD), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Practical Nursing Students, Personal Support Workers (PSW), Activation Aides (AA), Nursing Clerk (NC), Physiotherapist (PT), Dietary Aides (DA), the Cook, Maintenance Staff, resident's and family members.

The Inspectors also toured the home, observed staff to resident interactions during the provision of care, resident to resident interactions, observed meal services, medication administration and infection control practices, reviewed clinical health records, maintenance records, staffing schedules, resident's council and family council meeting minutes, licensee's investigation documentation and the licensee's policies related to infection control, falls prevention, personal assistance services device (PASD), skin and wound program, responsive behaviours, and resident abuse prevention program.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008's substitute decision-maker and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care specific to seating in the dining room.

Related to Log #005782-17

During an interview, resident #008's substitute decision-maker (SDM) indicated that they were not notified of the change in seating arrangement for resident #008 in the dining room. The SDM indicated to the inspector that they were surprised that the resident was moved to another table.

Review of the most recent MDS assessment and current plan of care for resident #008 indicated the resident's cognitive skills for daily decision-making was severely impaired.

Review of progress notes for resident #008 indicated an entry by RPN #119 on a specific date and time, that resident #008 responded to another resident's comment which irritated the co resident. Resident #008's response was to strike out at the co resident with a fork. The resident was told that this behaviour was not appropriate. RPN#119 moved resident #008 to another table. RPN #119 also changed the seating plan in the dining room to accommodate this. Dietary was notified. No further behaviour noted following the move.

Interviews with PSWs #142, #143 and #144 all indicated to the inspector that resident #008 is currently seated at table #6 and that the resident was moved from table #8.

On June 14, 2016, interview with RPN #119 confirmed that he/she moved resident #008 to a different table in the dining room on a specific date during the lunch meal. The RPN indicated that a PSW reported that resident #008 tried to hit a co resident with a fork. The Food and Nutrition Manager was notified of the change on the dame date that the move occurred. The RPN indicated that the resident agreed to move to a different table and that resident #008's SDM was not notified of the change of seating in the dining room as he/she does not normally notify the family of seating change in the dining room.

During an interview the Food and Nutrition Manager indicated no awareness of the table change that occurred on a specific date for resident #008. The Food and Nutrition

Manager indicated that the person who initiated the table change should have notified the SDM.

Resident #008's SDM was not given an opportunity to fully participate in the resident's plan of care when the SDM was not provided the opportunity to discuss the change in where the resident #008 was sitting in the dining room. [s. 6. (5)]

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

Resident #032 had diagnoses that includes cognitive impairment. On a specific date, during lunch meal service, inspector #461 observed that the resident was eating a minced meal consisting of minced ham, minced brussel sprouts and minced scalloped potatoes. The clinical records for resident #032 indicated a physician order for a regular diet, regular texture, regular fluids. A review of resident #032's current plan of care and diet list also indicated that resident was to receive a regular texture diet.

During an interview Dietary Aide #113 and PSW #109 indicated that resident has been receiving a minced diet for at least a month. RPN #111 and Nutrition Manager indicated that resident was to receive a regular diet, and confirmed that resident #032 was given the wrong texture diet. During an interview with the Registered Dietitian (RD) #117, RD indicated that resident #032's diet order has not changed and should be a regular diet with regular texture.

Resident #032's diet identified in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to falls prevention interventions for resident #012.

Related to log#011244-17

A Critical Incident Report (CIR) was submitted to the Director for an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. The CIR indicated the following; on a specific date and time resident #012 who has a diagnosis that includes dementia, was sitting in the lounge participating in a group activity. Resident was observed by Activity

Aide (AA) #136 to get up from the chair and attempt to walk while carrying the chair alarm. Resident #012 appeared to lose footing resulting in a fall landing on his/her right side. Resident was assessed for injury and transferred to hospital for further assessment. Resident #012 experienced a fracture that required surgery as a result of the fall.

Review of the current plan of care in Point Click Care (PCC) identifies the following;

Falls risk, interventions include the following;
- Bed Alarm applied on bed. Ensure bed alarm is applied and in working order.
- chair alarm

Review of the tasks in Point of Care (POC) documentation for the PSW's identified the following interventions for resident #012 to be documented on once every shift;
- Ensure mobility alarms are in place on bed.
- Chair alarm is working and in place.

On a specific date and time Inspector #623 observed resident #012 sitting in the lounge in front of the nursing station. Resident #012 was in a wheel chair with no chair alarm in place.

During an interview PSW #145 indicated that he/she was not aware of the falls interventions for resident #012. PSW was unable to indicate if a chair alarm was to be in place for resident #012. PSW #145 indicated that he/she usually works the night shift and has never seen resident #012 up out of bed so was not sure of the resident's needs. PSW #145 indicated that he/she is aware that resident care is to be provided according to the plan of care.

During an interview RPN #119 indicated that according to the plan of care in Point Click Care (PCC) for resident #012 falls prevention intervention identify a chair alarm in place when resident is up in the wheel chair. RPN #012 confirmed that resident #012 was sitting up in a wheel chair and there is no chair alarm in place.

During an interview RPN #107 indicated that resident #012 was assessed upon return from hospital and falls prevention interventions were put into place which included a chair alarm, bed alarm. RPN #107 indicated that the current plan of care in Point Click Care (PCC) identifies these interventions as well as the Point of Care (POC) tasks for the PSW's. RPN #107 confirmed that resident #012 was sitting in a wheel chair and there

was no chair alarm in place as indicated in the plan of care.

The care set out in the plan of care was not provided to resident#012 as specified in the plan related to falls prevention interventions. [s. 6. (7)]

4. The licensee has failed to ensure the plan of care was provided to resident #016 as specified in the plan related to falls prevention and management.

Review of clinical records for resident #016 indicated the resident has multiple diagnosis including cognitive impairment. The resident was identified as high risk for falls.

Review of the progress notes for resident #016 (for a specified six month time period) indicated the resident sustained 10 falls during that time.

On a specific date and time, the progress notes indicated that the resident was found with back against bed and feet towards window. Floor mat was not on floor (rolled up beside bed); Resident had been self transferring into a wheelchair.

Review of the licensee's Falling Star/Leaf Flagging Guide Appendix 5, policy #RC-06-04-01 indicated the purpose of the Falling Star/Falling Leaf Program is to identify residents at high risk of falls or fall injuries and clearly communicate to staff and other care team members standard
interventions for reducing risk.
The following residents will be flagged:
- score > 7 on Scott Fall Risk Screen OR
- score >1 on Fracture Risk Assessment

Review of the current plan of care for resident #016 indicated the resident is a high risk for falls related to multiple diagnosis, unsafe ambulation, Scotts Fall Risk Assessment score > 7 and Fracture Risk Screen score of > 1 indicating high risk for fracture.
Interventions included in the plan of care:
- Fall mat on floor while resident is in bed and tucked away if resident is out of the bed.
- Falling star logos in place above bed, on all ambulation equipment.

Observation of resident #016 on a specific date by Inspector #570 indicated the Falling Star logo was not in place in resident's room or on resident's equipment.
During interviews with RPN #124, PSW #123 and PSW #125, all indicated that resident #016 was at high risk for falls and that Falling Star logo should be posted in the

resident’s room on wall above head of bed. RPN #124, PSW #123 and PSW #125, all confirmed that there was no Falling Star logo posted for the resident as indicated in the plan of care.

During an interview with RN #146 who is the lead of falls prevention and management committee at the home indicated to Inspector #570 the expectation is that the plan of care should be followed and any resident identified at high risk for falls should have a falling star logo posted.

Care was not provided as directed in the plan of care to resident #016 when the fall mat was not in place when the resident sustained a fall on a specified date and when the Falling Star logo was not posted for the resident to indicate high risk for falls. [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan of care; and that the resident's substitute decision-maker and any other person designated by the resident or substitute decision-maker are given the opportunity to participate in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, had occurred or may occur, immediately report the suspicion and information upon which it was based to the Director.

Related to Intake #032618-16 :

A Critical Incident Report (CIR) was submitted to the Director on a specific date, regarding an alleged incident of resident to resident physical abuse. The CIR indicated that during the incident resident #052 sustained an injury. The incident was said to have occurred one day prior to the CIR being submitted to the Director.

On a specific date and time resident #051 and #052 was observed by PSW #140 arguing, kicking and punching at each other during a meal in the dining room. Resident #052 sustained an injury during the incident. Both residents were seated at the same table for meal service.

Resident #051 was admitted with diagnoses which include cognitive impairment.

Resident #052 was admitted with diagnoses which include cognitive impairment. Resident #052 also had a history of responsive behaviours.

In an interview with Inspector #626, RPN #140 confirm witnessing the alleged resident to resident physical abuse but was unaware that the incident was not reported to the Director until the following day, as it was immediately reported to the RN by RPN #140.

During an interview RN #108 who was on duty on the day of the incident they were not aware of the incident and indicated that another RN who is no longer employed by the home was the clinical lead that day.

The licensee failed to immediately report the alleged resident to resident physical abuse which occurred between resident #051 and #052 on a specific date until the following day, which is not immediately. [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 ensuring that person who had reasonable grounds to suspect that, abuse of a resident by anyone, had occurred or may occur, immediately report the suspicion and information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Intake #032618-16

A Critical Incident Report (CIR) was submitted to the Director on a specific date, indicating an alleged incident of resident to resident physical abuse. During the incident resident #052 sustained an injury.

The CIR indicated that on a specific date resident #051 and #052 were observed by PSW #140 arguing, kicking and punching at each other during a meal in the dining room, which resulted in an injury to resident #52 . Both residents were seated at the same table for meal service.

A review of the resident #051 and #052 health records did not indicate that the Substitute Decision Makers (SDM) of both residents were notified of the results of the investigation upon the completion.

Resident #051 was admitted with diagnosis which include cognitive impairment.

Resident #052 was admitted with diagnosis which include cognitive impairment. Resident #052 also has a history of responsive behaviours.

During an interview, the Administrator indicated being uncertain if the SDM of residents #051 and #052 were informed of the result of the investigation.

Inspector #626 was unable to locate any documentation indicating that the SDM for resident #051 or #052 were notified of the results of the investigation. The licensee has failed to ensure that the resident #051 and resident #052 SDMs were notified of the results of the alleged abuse or neglect investigation upon the completion. [s. 97. (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 ensuring that the resident and resident's SDM, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2)., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that drugs were administered to residents #046, #047 and #048 in accordance with the directions for use specified by the prescriber.

Related to log #029698-16

On a specific date, a compliant was submitted to the Director indicating that medications were not being given, and narcotics weren’t given out.

A review of the Licensee's Medication Incident reports for a specified month, revealed that resident #046, #047 and #048 did not receive their medication as prescribed by the physician.

Resident #046 was admitted into the home on a specific date. The resident’s Medication Administration Record (MAR) for a specific month indicated an order for a specified medication. A review of a medication incident report indicated that the resident's medication was not given on a specific date and time but signed off as given. A review of the Individual Controlled and Narcotic Drug Form (i.e. the count sheet) for resident #046

indicated that the current count of the specific medication was documented as nine on two consecutive days.

Resident #047 was admitted to the home on a specific date. A review of the residents MAR for a specific month indicated an order for a specified medication for two weeks then reassess. A medication incident report on a specific date identified the following. Medication not administered on a specified date as prescribed, found in drawer. The missed medication pouch was observed by Inspector #624 to be attached to the Medication Incident/Near Miss Report with the date and time on pouch clearly identified the date and time. A review of the attached MAR for a specific month also indicated the medication was signed as administered.

Resident #048 was admitted into the home on a specific date. The resident’s MAR for a specific month indicated an order for a specific medication. A review of a medication incident report indicated the specific medication was not administered and was found in a medication pouch in resident's med bin. The medication was signed on the MAR as given for that date and time. The missed medication pouch was observed by Inspector #624 to be attached to the Medication Incident/Near Miss Report with the date and time on pouch clearly identified. A review of the attached MAR for the specific month also indicated the medication was signed as administered on that specific date and time.

The medication incident reports, indicated that the residents were assessed with no noted adverse reaction to any of the residents. The physician, pharmacist, DOC, resident and or family where required were notified in each incident.

Inspector #624 was unable to contact the complainant to be interviewed during the period of the inspection.

In an interview conducted by Inspector #624 with Acting DOC #101 and RN #108 who was the charge RN on the date of the incident involving resident #048, both staff members, after reviewing all three incidents, indicated that the home’s expectation is that medications have to be administered as ordered by the physician. They also indicated that in all three incidents above, the drugs were not administered to residents #046, #047 and #048 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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

Related to Log #005782-17

Review of physician's orders for resident #008 indicated: a specified treatment, apply to affected area(s) topically on a specified day, as directed.

Review of resident #008's progress notes and treatment administration record (TAR) for a two month period indicated the resident did not receive the treatment as directed by the physician on two specific occasions.

During an interview the Acting DOC indicated that the treatment is supplied by the pharmacy provider and it should be applied to the resident as directed by the physician's order. [s. 131. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure that a written record is kept of the quarterly review of medication incidents and adverse drug reactions that have occurred in the home as well as ensure that any changes and improvements identified in the review are implemented.

A review of the medication incidents and adverse drug reaction records of the home for the period of six months was completed by Inspector #624. The review indicated that there were no written records kept by the home indicating that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home. There was also no written record demonstrating that changes and improvements identified in the review were implemented.

In an interview with the Acting Director of Care (ADOC) #102 and RN #108 (a member of the Medication Management Team), both staff members indicated that a review of the medication incidents and adverse drug reactions is completed during the quarterly Professional Advisory Council (PAC) meetings.

A review of the PAC meeting minutes was completed with Acting DOC. The minutes of the PAC meeting did not indicate that the medication incidents and adverse drug reactions were reviewed.

The ADOC indicated that an audit of the home’s medication management system was completed by the Medication Management Team in May 2017 and that a review of the whole medication management system, medication incidents and adverse drug reaction included, was completed and recommendations made to improve the process. A review of the minutes of this meeting as well as the recommendations arrived at, did not provide a written record of the quarterly review of medication incidents and adverse drug reactions and no written records indicating that any changes and improvements identified in the review were implemented.

The Licensee failed to keep a written record indicating that a quarterly review was undertaken of all medication incidents and adverse drug reactions and a written record of any changes and improvements identified in the review were implemented [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that a written record is kept of the quarterly review of medication incidents and adverse drug reactions that have occurred in the home as well as ensure that any changes and improvements identified in the review are implemented, to be implemented voluntarily.

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

Findings/Faits saillants :

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

Related to log #035045-16:

A critical incident report (CIR) was submitted to the Director on a specific date. The CIR indicated that RPN #133 went to assess resident #049 on a specific date, and noted that resident was very shaky and refused vitals to be done. RPN noted that resident became angry and jumped out of bed with both fists swinging and feet kicking towards the RPN. RPN #133 ran quickly out of resident’s room and had to hold the door shut while resident was trying to pull the door open. Resident finally let go of the door and went on to lay in his bed. An amendment to the CIR completed on a specific date, indicated that GPA re-training will commence and that pending outcome of investigation will determine long-term actions.

During an interview, the Administrator confirmed that the results of alleged abuse or neglect investigation that occurred six months prior, were not reported to the Director.

Licensee failed to report the results of the alleged resident to resident abuse or neglect investigation to the Director. [s. 23. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. The Long-Term Care Homes Act, 2007 s.8(1) (b) requires the home to have an organized program of personal support

services for the home to meet the assessed needs of the resident.

Related to Log #005782-17

A complaint was received by the MOHLTC indicating that resident #008 has not received a bath on several occasions; most of the time they said they were short staffed; the resident is supposed to get two baths a week but does not always happen.

Review of the current plan of care for resident #008 was completed indicating bath two specified days a week.

Review of progress notes for resident #008 indicated in relation to bathing that on a specific date and time, the resident did not receive a bath due to time constraints. Evening Clinical nurse was informed.

Review of the PSW documentation in the Daily Care flow sheets indicated no documentation that a bath was or was not provided to resident #008 on seven scheduled bath dates over a two month period.

During an interview the Administrator indicated that resident #008's substitute decision maker (SDM) spoke to him/her about the missed bath on the specified date. The Administrator further indicated that the resident received a bath the following day given by PSW #103 but this was not documented as given. During the same interview the Administrator and the Acting DOC, both indicated that the resident should receive a bath twice a week and if a bath was missed it should be documented and reported to the charge nurse to be rescheduled. Both the Administrator and the Acting DOC could not confirm if the resident received a bath on the seven scheduled bath dates as there was no documentation available.

Review of progress notes and PSW's documentation provided to the inspector indicated no documented evidence that the resident received a bath on the seven scheduled bath dates and there was no documented evidence that the missed bath dates were rescheduled or given at a later date.

Licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, specifically related to bathing. [s. 30. (2)]

WN #8: 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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions: the long-term actions planned to correct the situation and prevent recurrence

Related to log #035045-16:

A critical incident report (CIR) was submitted to the Director on a specific date. The CIR indicated that RPN #133 went to assess resident #049, and noted that resident was very shaky and refused vitals to be done. RPN noted that resident became angry and jumped out of bed with both fists swinging and feet kicking towards RPN. RPN #133 ran quickly out of resident #049's room and had to hold the door shut while resident was trying to pull the door open. Resident eventually let go of the door and went on to lay in his bed.
An amendment to the CIR completed on a specific date, indicated that Gentle Persuasive Approach (GPA) re-training will commence and that pending outcome of investigation will determine long-term actions.
During an interview, the Administrator indicated that it was determined RPN #133 and PSW #132 tried to protect other residents. The home was currently looking into improving the phone communication system and organizing a GPA refresh training for all staff to prevent re-occurrence of the similar event. The Administrator confirmed that the outcomes of the investigation and long-term actions were not communicated to the Director.

The licensee did not report to the Director the results of the alleged abuse or neglect investigation and long-term actions to correct the situation and prevent recurrence. [s. 104. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home:
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Related to Log # 006631-17

A critical incident report (CIR) was submitted to the Director on a specific date and time, for an unexpected death of resident #055 that occurred one day prior.

The CIR indicated on a specific date and time, two staff were assisting resident #055 with toileting. Staff had stated the resident's knees buckled and the resident was lowered to the floor by the two staff who heard a pop. Physician was informed of incident and an x-ray was ordered. The x-ray results received four days later indicated there was a pathological fracture.

A review if the CIR and clinical records for resident #055 indicated the resident passed away on a specific date and time. The Corner was informed and indicated immediate cause of death was related to the fracture.

During an interview RN #146 who submitted the CIR to the Director, indicated that the unexpected death of resident #055 was not immediately reported to the Director.

The Director was not notified of resident #055's death until one day after the passing of the resident, when a CIR was submitted notifying the Director of the unexpected death. [s. 107. (1)]

Issued on this 29th day of June, 2017

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

Original report signed by the inspector.