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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2014	2014_140158_0004	S-000008-14	Resident Quality Inspection

Licensee/Titulaire de permis

VALLEY EAST LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

ELIZABETH CENTRE
2100 Main Street, Val Caron, ON, P3N-1S7

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

KELLY-JEAN SCHIENBEIN (158), FRANCA MCMILLAN (544), TIFFANY BOUCHER (543)

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): March 3 to March 7, 2014 and March 10 to 14, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Co-Directors of Care, Registered Nursing Staff, Personal Support Workers, Environmental Services Manager, Food Services Manager, Registered Dietitian, RAI Coordinator, Dietary aides, Housekeeping/laundry staff, Recreational Co-ordinator, Resident Council members, Family Council members, Families and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident home areas, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
On March 03, 2014 at 09:45h, Inspector # 544 observed staff # 104, who had "Pieces" training, speaking to (cognitively impaired) resident # 201. Resident # 201 asked to go to a different area of the home to which staff # 104 quickly responded in a raised voice that "there is there is no such area in this home." Staff # 104 then moved resident #

201 and the walker abruptly in the direction of the resident's room. Resident # 201 became teary eyed and agitated. The licensee did not ensure that resident # 201 was treated with courtesy and respect by staff # 104. [s. 3. (1) 1.]

2. Resident # 200 had a choking incident while eating a meal. The resident's respiratory condition worsened and the resident was admitted into the hospital.
Staff # 100 provided the Administrator and DOC, a copy of a written letter of concern (written by staff # 100) regarding neglect of resident # 200. (Inspector # 543 received a copy of this letter on March 12/14) This letter identified that the Registered staff was not supervising residents while they ate (as per Registered staff routine) but was at the desk on the phone. The letter further describes, that the Registered staff failed to immediately assist resident # 200 when the resident choked.
The letter also identified, that a second Registered staff (staff # 102) who was asked to assist, was uncertain how to use the suction machine and that another suction machine from a different area was used to suction the resident. (the first suction machine was functional at the time of the incident) In discussion with the home's educator, Staff # 103 identified to Inspector # 543, that education related to the suction machine is not routinely provided and that no education regarding use of suction machines was provided post incident.
This allegation of neglect brought forward to the Administrator and DOC in a written letter of concern was not reported to the Director nor was the Director informed of the written letter of concern (complaint).
On March 12, 2014, Inspector # 543 reviewed resident # 200's health care record, which included MDS assessments, progress notes and care plan. Resident # 200's admission nutritional assessment, which would identify a resident's choking risk or swallowing difficulty, was incomplete.
The progress notes identified that the dietitian did observe resident # 200 eating post choking episode and identified that the resident was at risk of choking. The dietitian identified that there would be no change to the interventions on the care plan. (there were no interventions documented) The dietitian also documented that the resident had behavioural responses during meals, which put the resident and staff at risk of injury.
On March 12, 2014, Inspector # 543 reviewed resident # 200 care plan, which did not identify the resident's choking risk, interventions to manage the choking episodes, the resident's behavioural responses during meals or interventions to manage the responses.
Inspector # 158 and # 543 met with the DOC and the Administrator on March 13, 2014, regarding the choking episode involving resident # 200 and the current care

plan, which lacked clear direction.
The resident's care plan was updated on March 13, 2014. The choking risk and interventions were now identified however, the plan did not identify resident # 200's behavioural responses during meals or interventions to manage the responses.
The licensee did not ensure that resident # 200 was protected from neglect. [s. 3. (1) 3.]

3. The licensee did not fully respect and promote the resident's right to participate fully in the development, implementation, review and revision of his or her plan of care.
Resident # 7978 told Inspector # 158 on March 4, 6 and 13, 2014, that the staff decide when to bathe them and that at times the baths are done when the resident is tired or actively participating in other events. Resident # 7978 stated that the staff do not listen to their requests and fears that they would miss their bath.
It was identified by the Nurse Coordinator that residents are asked their preference with bathing. However, it was identified in interview with front line staff (Staff # 105 and # 106) that the resident bath days are scheduled according to what bed the resident occupies in their room. When asked about the resident's preference, both staff # 105 and staff # 106 identified that at times, it is difficult to accommodate the resident's preference, as the other residents in the unit, are reluctant to change their bath day. Staff # 107 and staff # 108 identified that they follow the bathing schedule when interviewed by Inspector # 158.
Inspector # 158 reviewed resident # 7978 health care record, which included the progress notes, flow sheets and plan of care. The resident's bathing preference was documented in resident # 7978 plan of care. Resident # 7978 flow sheet records indicated that the resident received their bath on the care planned days, but at various times later in the day. The progress notes were reviewed and verification that a bathing choice/time was given, was not found.
The licensee did not ensure that resident # 7978 right to fully participate in the implementation of their plan of care related to bathing was respected. [s. 3. (1) 11. i.]

4. The licensee did not fully respect and promote the resident's right to participate fully in the development, implementation, review and revision of his or her plan of care.
Resident # 7967 stated in interview with Inspector # 158 on March 4 and 6, 2014, that staff "just fit me in for a bath". I really didn't want the days they gave me.
It was identified by staff # 102 that residents are asked their preference with bathing. However, it was identified in interview with Staff # 105 and staff # 106 that the resident bath days are scheduled according to what bed the residents occupies in their room. When asked about the resident's preference, both staff # 105 and staff # 106

identified that at times it is difficult to accommodate the resident's preferences as the other residents in the unit are reluctant to change. Staff # 107 and staff # 108 identified that they follow the bathing schedule when interviewed by Inspector # 158. Inspector # 158 reviewed resident # 7967 health care record, which included the progress notes, flow sheets and plan of care. The resident's bathing preference was documented in resident # 7967 plan of care. The progress notes were reviewed and there was no indication that a choice was given.
The licensee did not ensure that resident # 7967 right to fully participate in the implementation of the plan of care related to bathing was respected. [s. 3. (1) 11. i.]

5. The licensee also did not ensure that resident # 7978 right to fully participate in the implementation of their plan of care related to getting up in the morning was respected.
The Inspector reviewed resident # 7978 progress notes on March 13, 2014. It was documented by staff # 105 that resident # 7978 was very upset and crying as a unidentified PSW was abrupt and with a loud voice stated that resident # 7978 had to get up for breakfast. Resident # 7978 responded that they get up on their own and doesn't always want to get up for breakfast. Resident # 7978 plan of care was reviewed and the resident's above preference was not documented. [s. 3. (1) 11. i.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and did not ensure that residents are not neglected by the licensee or staff.
Two Critical Incidents, both regarding staff to resident verbal abuse by staff # 114, were reported to the Director at two separate times on the same day. It was identified

in the first Critical Incident that staff # 121 heard staff # 114 verbally abusing resident # 204. A second incident of verbal abuse by staff # 114 occurred two hours later, when staff # 120 heard staff # 114 say to resident # 205 "we all have a job to do, so leave us alone".
Inspector # 158 spoke with the DOC on March 20, 2014 regarding the information provided in the Critical Incidents. The DOC clarified the following:
- that staff # 121 alluded to the incident of the first verbal abuse at the managers' meeting
- that No action was taken regarding the abuse incident until both staff # 121 and staff # 120 came forward two hours after the second abuse occurred and after the managers' meeting
- that the staff could have reported the incidents immediately to anyone (i.e administrator), but had not.
The DOC identified that staff # 114 was approached after their lunch and then sent home.
Inspector # 158 reviewed the home's policy titled Resident Rights, Care, and Services Abuse (2558- 2563) which identified that "suspected and or confirmed allegations of abuse shall be reported immediately to the Administrator, DOC if the Administrator is not in the home or to the Charge Nurse if the DOC is not in the home and that the "abuser" would be removed from the situation and placed off work with pay pending the investigation of the incident". As confirmed by the DOC, the home's abuse policy was not followed.
The Licensee failed to protect residents, in particular resident # 204 and resident # 205, from abuse through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)]

2. During the resident interviews, it was identified by resident # 7978, resident # 7967 and resident # 8023, that staff # 113 was rude, abrupt, loud and disrespectful to residents (especially residents who are cognitively impaired) residing in one area of the home.
Inspector # 544 spoke with the 3 residents on March 10, 2014 and they re-confirmed the allegation of verbal abuse.
On March 10, 2014, Inspector # 544 spoke to the DOC regarding the allegations of verbal abuse made about staff # 113. The DOC identified that staff # 113 was disciplined for previous instances of verbal and emotional abuse of residents.
Staff # 113's employee file, which was reviewed by Inspector # 544 contained letters showing progressive discipline and actions to prevent further abuse.
Inspector # 158 reviewed the home's policy titled Resident Rights, Care, and Services

– Abuse (2558- 2563) which identified that a Critical Incident Report is to be initiated when an alleged incident of abuse is reported and that the alleged abuser would be off with pay pending investigation of the incident. It is further identified that when abuse has been validated, a staff member may be disciplined with an oral reminder, written warning, suspension or terminated.
Inspector # 158 reviewed the CI regarding the above allegation. The information in the CI report did not reflect what Inspector # 544 had conveyed to the DOC on March 10, 2014. The CI report instead contained information that Inspectors # 158 and 543 had conveyed to the DOC on March 12, 2014.
The Critical Incident Report identified the home's long-term actions,however, these were the same actions identified in staff # 113 last discipline.
The Licensee failed to protect residents, in particular resident # 7978, # 7967 and # 8023, from abuse through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)]

3. According to a Critical Incident, resident # 203 approached staff # 111 and staff # 112, requesting assistance for another resident. Resident # 203 later re-approached staff # 111 in the dining room identifying that it had been 30 minutes and assistance had not been provided. Staff # 111 responded to resident # 203, in the presence of residents and staff, in an elevated voice, described by staff as "screaming and barking" at the resident.
In an interview with Inspector # 544 on March 10, 2014, the DOC identified that resident # 203 reported the incident of neglect and verbal abuse to them and that a complaint investigation was initiated. The DOC confirmed that no staff member had reported the neglect or verbal abuse incident to the Administrator, DOC or Charge Nurse.
Inspector # 158 reviewed the home's policy titled Resident Rights, Care, and Services – Abuse (2558- 2563), which identified that "suspected and or confirmed allegations of abuse shall be reported immediately to the Administrator, DOC, if the Administrator is not in the home or to the Charge Nurse, if the DOC is not in the home; that a Critical Incident Report is to be initiated when an alleged incident of abuse is reported and that the alleged abuser would be off with pay pending investigation of the incident.
A Critical Incident regarding staff to resident verbal abuse was reported to the Director, however, it was not immediately reported, as required.
A copy of staff # 111's discipline, identified that a meeting to discuss verbal abuse toward the resident was held with the administrator and staff # 111. The Critical Incident identified that a second disciplinary meeting with the DOC was held 11 days later. According to the staffing schedule, Inspector # 158 noted that staff # 111 was

scheduled to work 4 days during the investigation. The DOC confirmed that according to staff # 111 time cards, staff # 111 did work those days during the investigation.
The Licensee failed to protect residents, in particular resident # 203 and another resident from abuse through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)]

4. Resident # 200 had a choking incident while eating a meal. The resident's respiratory condition worsened and the resident was admitted into hospital.
Staff # 100 provided the Administrator and DOC, a copy of a written letter of concern (written by resident # 100) regarding neglect of resident # 200. (Inspector # 543 received a copy of this letter on March 12/14) This letter identified that the Registered staff was not supervising residents while they ate (as per Registered staff routine) but was at the desk on the phone. The letter further describes, that the Registered staff failed to immediately assist resident # 200 when the resident choked.
The letter also identified, that a second Registered staff (staff # 102) who was asked to assist, was uncertain how to use the suction machine and that another suction machine from a different area was used to suction the resident. (the first suction machine was functional at the time of the incident) In discussion with the home's educator, Staff # 103 identified to Inspector # 543, that education related to the suction machine is not routinely provided and that no education regarding use of suction machines was provided post incident.
This allegation of neglect brought forward to the Administrator and DOC in a written letter of concern was not reported to the Director nor was the Director informed of the written letter of concern (complaint).
On March 12, 2014, Inspector # 543 reviewed resident # 200's health care record, which included MDS assessments, progress notes and care plan. Resident # 200's admission nutritional assessment, which would identify a resident's choking risk or swallowing difficulty, was incomplete.
The progress notes identified that the dietitian did observe resident # 200 eating post choking episode and identified that the resident was at risk of choking. The dietitian identified that there would be no change to the interventions on the care plan. (there were no interventions documented) The dietitian also documented that the resident had behavioural responses during meals, which put the resident and staff at risk of injury.
On March 12, 2014, Inspector # 543 reviewed resident # 200 care plan, which did not identify the resident's choking risk, interventions to manage the choking episodes, the resident's behavioural responses during meals or interventions to manage the responses.

Inspector # 158 and # 543 met with the DOC and the Administrator on March 13, 2014, regarding the choking episode involving resident # 200 and the current care plan, which lacked clear direction.
The resident's care plan was updated on March 13, 2014. The choking risk and interventions were now identified however, the plan did not identify resident # 200's behavioural responses during meals or interventions to manage the responses.
The licensee did not ensure that resident # 200 was protected from neglect. [s. 19. (1)]

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 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).

Findings/Faits saillants :

1. It was identified in a recent MDS assessment that resident # 8023 had altered skin integrity. It was confirmed on March 10, 2014 by the dietitian and staff # 105, that the resident continues to have altered skin integrity.
On March 10, 2014, resident # 8023 plan of care was reviewed by Inspector # 158. The identification of the altered skin integrity was documented under the problem "potential for ulceration", however, the wound, the current physician treatments and nursing interventions was not documented on the care plan.
The licensee did not ensure that there was a written plan of care for resident # 8023 that sets out clear directions to staff and others who provide direct care to manage the

resident's altered skin integrity. [s. 6. (1) (c)]

2. Staff # 109 documented in the progress notes that resident # 7969 was sent to hospital for assessment. It was further documented that the resident was admitted and returned to the home with a diagnosis of a specific infection.
Inspector # 158 noted that assessments, such as head to toe skin assessments, a continence assessment and pain assessment, (which were completed prior to resident # 7969's hospitalization) indicated that resident # 7969 had a history of developing this same infection.
On March 10, 2014, Inspector # 158 reviewed resident # 7969 care plan and the identification of the resident's risk of developing this specific infection and preventative measures, were not included in resident # 7969 plan of care.
The licensee did not ensure that there was a written plan of care that sets out clear directions to staff and others who provide direct care to the resident related to preventing or managing their infection for resident # 7969. [s. 6. (1) (c)]

3. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
It was identified in resident # 7978 MDS assessment that the resident was verbally aggressive to other residents. It was documented in resident # 7978 progress notes that episodes of verbal aggression to other residents have occurred in the past. On March 13, 2014, Inspector # 158 spoke with staff # 123, who confirmed that resident # 7978 continues to be verbally aggressive with other residents.
Inspector # 158 reviewed resident # 7978 care plan and although verbal aggression is identified, the plan of care does not identify resident # 7978 verbal aggression towards other residents or provide direction to manage or prevent resident # 7978 verbal aggression towards them. [s. 6. (1) (c)]

4. Resident # 200 had a choking incident while eating.
On March 12, 2014, Inspector # 543 reviewed resident # 200 health care record, which included MDS assessments, progress notes and care plan. The records identified that resident # 200 admission nutritional assessment, which would identify a resident's choking risk or swallowing difficulty was incomplete.
The progress notes identified that the dietitian did observe resident # 200 eating post choking episode and identified that the resident was at risk of choking. The dietitian identified that there would be no change to the interventions on the care plan. (there were no interventions documented) The dietitian also documented that the resident had behavioural responses during meals, which put the resident and staff at risk of

injury.
On March 12, 2014, Inspector # 543 reviewed the Resident # 200 care plan, which did not identify the resident's choking risk, interventions to manage the choking episodes, the resident's behavioural responses during meals or interventions to manage the responses.
On March 13, 2014, Inspector #543 spoke with DOC and Administrator and both concurred that resident #200's care plan should in fact have been updated to reflect resident's risk for choking.
The licensee did not ensure that there was a written plan of care that sets out clear directions to staff and others who provide direct care to the resident # 200 related to their choking risk. [s. 6. (1) (c)]

5. Inspector # 543 reviewed the care plans, health care records and bath assignment sheets of various residents who reside in Home Area 3.
Resident # 8092's care plan identified the resident's bathing preferences. The care flow sheet documentation showed that the resident's bathing preferences were not provided, as set out in resident # 8092 care plan.
Resident # 7983's care plan identified the resident's bathing preferences. The care flow sheet documentation showed that the resident's bathing preferences were not provided, as set out in resident # 7983 care plan.
Resident # 7993's Care Plan identified the resident's bathing preferences. The care flow sheet documentation showed that the resident bathing preferences were not provided, as set out in resident # 7993 care plan.
Resident # 8040's Care Plan identified that that the resident's bathing preferences. The care flow sheet documentation showed that the resident bathing preferences were not provided, as set out in resident # 8040 care plan.
The licensee did not ensure that the care set out in the plan of care was provided to four residents as specified in their plans. [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 resident # 8023 plan of care sets out clear directions to staff and others who provide direct care related to the management of the altered skin integrity; that resident # 7969 care plan sets out clear directions to staff and others who provide direct care related to managing and preventing a specific infection; that resident # 7978 plan of care sets out clear directions to staff and others who provide direct care related to verbal aggression towards residents; that resident # 8040 plan of care sets out clear directions to staff and others who provide direct care related to bathing; and that resident # 200 care plan sets out clear directions to staff and others who provide direct care related to choking risks, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On March 3, 2014, Inspector 544 conducted an initial tour of the home. The floor tiles in two shower rooms were cracked, chipped and were lifting. Black debris was also observed on some of these tiles. Inspector # 544 also observed that the metal corners of the wall located in a resident's room were visible, where the drywall had fallen off and required repair and the walls in one of the Home Areas, were scuffed and required painting.
On March 4, 2014, Inspector # 158 observed that resident # 8043 and resident # 7962 bed room walls were scratched, gouged and required repair. It was also observed by Inspector # 158 that the walls in the hallways of their Home Area were scratched and some of the walls were gouged and required painting.
The licensee did not ensure that the home, furnishings and equipment were maintained in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the walls with gouges and scratches are repaired and painted, and that the tiles which are loose, cracked, chipped and lifting are repaired or replaced, to be implemented voluntarily.

WN #5: 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. According to a Critical Incident, resident # 203 approached staff # 111 and staff # 112, requesting assistance for another resident. Resident # 203 later re-approached staff # 111 in the dining room identifying that it had been 30 minutes and assistance had not been provided. Staff # 111 responded to resident # 203, in the presence of other residents and staff, in an elevated voice, described by staff as "screaming and barking" at the resident. A Critical Incident regarding staff to resident verbal abuse was reported to the Director, however, it was not immediately reported, as required. The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding abuse of a resident by anyone or neglect of a resident by the licensee or staff. [s. 24. (1)]

2. On March 12th, 2014, Inspector # 543 received from staff # 100, a copy of a letter (written by staff # 100), concerning alleged neglect of resident # 200 by staff. Staff # 100 informed the Inspector that they (staff # 100) had given a copy of the written letter to the DOC and Administrator. A Critical Incident regarding the alleged neglect was not reported to the Director, as required. [s. 24. (1)]

3. During the resident interviews, it was identified by resident # 7978, resident # 7967 and resident # 8023 that staff # 113 was rude, abrupt, loud and disrespectful to residents (especially residents who are cognitively impaired) residing in one area of the home. Inspector # 544 spoke with the 3 residents on March 10, 2014 and re-confirmed the allegation of suspected verbal abuse.
On March 10, 2014, Inspector # 544 spoke to the DOC regarding the allegations of suspected abuse made about staff # 113. A Critical Incident regarding this new allegation of suspected verbal abuse was not immediately reported to the Director. The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding abuse of a resident by anyone or neglect of a resident by the licensee or staff. [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 all suspicions and the information upon which they are based are reported immediately to the Director, re:abuse of a resident by anyone, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with the following weight changes, a change of 5 per cent of body weight, or more, over one month; a change of 7.5 percent of body weight, or more, over three months ; a change of 10 per cent of body weight, or more, over 6 months and any other weight change that compromises the resident's health status are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

1. Inspector # 158 reviewed the health care record, which included the MDS assessments, weights, and care plan for resident # 7979. Resident # 7979's had a weight loss of 5.2 kg (5%) in one month.
On March 6, 2014, the Dietitian told the Inspector that the home's policy identifies that residents are to be re-weighed when there is a 5% change over 1 month. There was no documentation to verify that resident # 7979 was re-weighed or that the resident was assessed.

2. Inspector # 158 reviewed the health care record, which included the MDS assessments, weights, and care plan for resident # 8036. Resident # 8036 had a weight gain of 3.4 kg (5%) in one month.
On March 6, 2014, the Dietitian told the Inspector that the home's policy identifies that residents are to be re-weighed when there is a 5.0% change and that a referral is usually sent to them to assess the resident. A review of the weights documented in Point Click Care showed that resident # 8036 was not re-weighed. A review of the nutritional assessments showed that the last referral/assessment by the dietitian was done prior to this weight change. A new referral for assessment was not completed.

3. Inspector # 158 reviewed the health care record, which included the MDS assessments, weights, and care plan for resident # 7997. Resident # 7997 had a weight gain of 5.9 kg (5%)in one month.
On March 6, 2014, the Dietitian told the Inspector that the home's policy identifies that residents are to be re-weighed when there is a 5% change and that a referral is usually sent to the dietitian to assess the resident. A review of the weights documented in Point Click Care showed that resident # 7997 was not re-weighed. A review of the nutritional assessments showed that the last referral/assessment by the dietitian was done prior to this weight change. A new referral for assessment was not completed.

4. Inspector # 158 reviewed the health care record, which included the MDS assessments, weights, and care plan for resident # 8007. Resident # 8007 had a loss of 5.6 kg in three months.
On March 6, 2014, the Dietitian told the Inspector that the home's policy identifies that residents are to be re-weighed when there is a 7.5% change and that a referral is usually sent to them to assess the resident. A review of the weights documented in Point Click Care showed that resident # 8007 was not re-weighed. A review of the nutritional assessments showed that the last referral/assessment by the dietitian was done prior to this weight change. A new referral for assessment was not completed.

5. Inspector # 158 reviewed the health care record, which included the MDS assessments, weights, and care plan for resident # 7982. Resident # 7982 had a loss of 3.2 kg (5%) in one month. On March 6, 2014, the Dietitian told the Inspector that the home's policy identifies that residents are to be re-weighed when there is a 5% change over 1 month. A review of the weights documented in Point Click Care showed that resident # 7982 was not re-weighed.
The licensee did not ensure that resident # 7979, # 8036, 7997, # 8007, and # 7982, who had weight changes, were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated. [s. 69.]

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 all residents with weight changes are assessed using an interdisciplinary approach, particularly resident # 7979, # 8036, # 7997, # 8007, and # 7982, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. On March 10, 11, and March 12, 2014, Inspector # 544 observed that the PSWs serving a meal in a Home Area were not wearing aprons.
Staff # 114 and Staff # 115 confirmed that there were no aprons on the unit and that Management was to order more. The staff also stated "They are often short of aprons during meals".
As per Home's policy-Resident Rights, Care and Services - Nutrition Care and Hydration Programs-Multidisciplinary Dining Room, staff will wear a clean apron during meal service in the dining room and ensure proper hand washing procedures are adhered to throughout the meal.
The licensee did not ensure that all food and fluids in the food production system are served using methods to prevent adulteration, contamination and food borne illness. [s. 72. (3) (b)]

2. The licensee did not ensure that all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.
The home's procedure identified that the temperature of the refrigerator is to be between 2-8 degrees Celsius or 35-40 degrees Fahrenheit.
On March 14, 2014, Inspector # 158 observed that the documented refrigerator temperatures in one of the serveries were below the temperatures identified on the home's procedure. Inspector # 158 also observed that milk, fortified milk, butter, and yogurt were stored in the refrigerator located in both serveries.
There were 13 daily temperatures taken in a 14-day span with only 2 days when the temperature values were between 2-8 degrees Celsius or 35-40 degrees Fahrenheit.
Inspector # 158 reviewed the documented temperatures of the refrigerator located in the other servery. There were 13 daily temperatures taken in a 14-day span with 4 days when the temperature values were not between 2-8 degrees Celsius or 35-40 degrees Fahrenheit.
The licensee did not ensure that all food and fluids (milk, fortified milk, butter, and yogurt) were stored using methods to prevent adulteration, contamination and food borne illness. [s. 72. (3) (b)]

3. The licensee did not ensure that the staff of the home comply with policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.
Throughout the inspection, the Inspectors noted a burnt toast odour every morning throughout the home.
Inspector # 158 observed that the toasters in the serveries had pieces of burnt debris and had areas which were coated with baked on burnt debris.
On March 14, 2014, staff # 116 identified to Inspector # 158 that the bread is not evenly toasted and the edges become burnt. Staff # 116 also identified that at times the toast, especially raisin toast is set on fire during the toasting process. This was confirmed by staff # 117.
It was identified by staff # 116 and staff # 117 that the burnt debris collects in the tray below the grill and cleaning of this area is not done by dietary staff.
The home did not ensure that procedures for safe operation and cleaning of the toasters were complied with. [s. 72. (7) (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 ensuring that all food and fluids (milk, fortified milk, butter, and yogurt) are stored in refrigerators with temperatures between 2-8 degrees Celsius or 35-40 degrees Fahrenheit as identified in the home's procedure; that equipment such as toasters are safe to operate and are cleaned regularly to prevent build up of debris which can easily be set on fire; that staff are provided with and wear aprons during meal service, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On March 12th, 2014, Inspector # 543 received from staff # 100, a copy of a letter (written by staff # 100), concerning alleged neglect of resident # 200 by staff. Staff # 100 informed the Inspector that they (staff # 100) had given a copy of the written letter to the DOC and Administrator. Inspectors # 543 and # 158 spoke with the DOC and Administrator on March 12, 2014, who confirmed that this written complaint was not forwarded to the Director as per LTCHA 2007, S.O 2007, c. 8, s. 22 (1)
The licensee failed to immediately forward to the Director a written complaint concerning the care of a resident or the operation of the long-term care home. [s. 22. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee did not ensure that strategies were developed and implemented to meet the needs of those residents with compromised communication and verbalization skills.
On March 5, 2014, Inspector # 158 interviewed resident # 7697 and observed that the resident had difficulty with enunciating words and became anxious as they struggled to answer the Inspector's questions.
Inspector # 158 reviewed resident # 7697 health care record, which included the MDS assessments, progress notes and care plan.
A MDS assessment was recently completed by staff # 118, which identified that resident # 7697 had compromised communication and verbalization skills, however, the resident's difficulty was not care planned.
Inspector # 158 reviewed resident # 7697 care plan and although anxiety was identified, the communication difficulties and subsequent interventions to manage the behaviour were not included in the care plan.
The licensee did not ensure that strategies were developed and implemented to meet the needs of resident # 7697 who has compromised communication and verbalization skills. [s. 43.]

WN #10: 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 :

1. The licensee did not ensure that the home's 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 in the home.
It was identified in a recent MDS assessment that resident # 8023 had altered skin integrity. It was confirmed on March 10, 2014 by the dietitian and staff # 105, that the resident continues to have altered skin integrity.
Inspector # 158 reviewed the home's policy "Skin and Wound Care" (Nov.16/13), which identified that a resident with altered skin integrity will receive a skin assessment/reassessment by a Registered staff, using a clinically appropriate assessment tool at least weekly. It is also identified that if the resident's impaired skin integrity is a wound, then the weekly documentation of the wound is completed in the wound progress notes. If the altered skin integrity is not a wound, the documentation is completed under skin note progress note.
Resident # 8028 health care record, which included the MDS assessments, wound progress notes and skin notes were reviewed by Inspector # 158.
It was noted by the Inspector that assessments of resident # 8023 altered skin, using a clinically appropriate assessment instrument, were documented in the wound progress notes, however, these assessments were dated 2013.
Resident # 8023 progress notes were reviewed by Inspector # 158 and there was no documentation found under "wound progress note" related to the current resident # 8023 altered skin. There was some documentation found regarding the treatment and dressing changes under skin note in the progress notes, however, this documentation was not completed weekly.
The licensee did not ensure that the home's 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 for resident # 8013, who is exhibiting altered skin integrity. [s. 48. (1) 2.]

WN #11: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure the food and fluids being served were at a temperature that is both safe and palatable to the residents.
On March 4, 2014, Inspector # 544 spoke with resident # 7981, who stated that their coffee, which was just served, was not as hot as they would like it. On March 10, 2014, resident # 7981 had expressed to Inspector # 544 that they were served cold to lukewarm coffee at meals and now drinks something else instead. Boiling water is placed directly in the cup but they find, however, that the liquid is then too hot to drink.

On March 11, 2014, resident # 7967 and resident # 7982 stated to Inspector # 158 that their coffee, which was just served, was cold.
The licensee did not ensure fluids were being served at a temperature that is palatable to the resident # 7981, # 7967 and resident # 7982. [s. 73. (1) 6.]

Issued on this 25th day of April, 2014

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

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

Ministère 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158), FRANCA MCMILLAN (544), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_140158_0004
Log No. / Registre no:	S-000008-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 24, 2014
Licensee / Titulaire de permis :	VALLEY EAST LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	ELIZABETH CENTRE 2100 Main Street, Val Caron, ON, P3N-1S7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELLY MURPHY

To VALLEY EAST LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

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

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

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

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

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

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

i. the Residents' Council,

ii. the Family Council,

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

iv. staff members,

v. government officials,

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the Registered staff are present in the home area dining rooms during meal service, that educational sessions are provided to staff related to choking interventions and that residents, including resident # 200, are assessed for choking risks and that the written plan of care addresses the risk and gives clear direction to staff providing care.

This plan is to be submitted to Inspector Kelly-Jean Schienbein (151), Health System
Accountablity and Performance Division, Sudbury Service Area Office, 159 Cedar Street, Suite 403, Sudbury, ON P3E 6A5 by May 2, 2014.

Grounds / Motifs :

1. Resident # 200 had a choking incident while eating a meal. The resident's respiratory condition worsened and the resident was admitted into the hospital. Staff # 100 provided the Administrator and DOC, a copy of a written letter of concern (written by staff # 100) regarding neglect of resident # 200. (Inspector # 543 received a copy of this letter on March 12/14) This letter identified that the Registered staff was not supervising residents while they ate (as per Registered staff routine) but was at the desk on the phone. The letter further describes, that the Registered staff failed to immediately assist resident # 200 when the resident choked.
The letter also identified, that a second Registered staff (staff # 102) who was asked to assist, was uncertain how to use the suction machine and that another

suction machine from a different area was used to suction the resident. (the first suction machine was functional at the time of the incident) In discussion with the home's educator, Staff # 103 identified to Inspector # 543, that education related to the suction machine is not routinely provided and that no education regarding use of suction machines was provided post incident.
This allegation of neglect brought forward to the Administrator and DOC in a written letter of concern was not reported to the Director nor was the Director informed of the written letter of concern (complaint).
On March 12, 2014, Inspector # 543 reviewed resident # 200's health care record, which included MDS assessments, progress notes and care plan.
Resident # 200's admission nutritional assessment, which would identify a resident's choking risk or swallowing difficulty, was incomplete.
The progress notes identified that the dietitian did observe resident # 200 eating post choking episode and identified that the resident was at risk of choking. The dietitian identified that there would be no change to the interventions on the care plan. (there were no interventions documented) The dietitian also documented that the resident had behavioural responses during meals, which put the resident and staff at risk of injury.
On March 12, 2014, Inspector # 543 reviewed resident # 200 care plan, which did not identify the resident's choking risk, interventions to manage the choking episodes, the resident's behavioural responses during meals or interventions to manage the responses.
Inspector # 158 and # 543 met with the DOC and the Administrator on March 13, 2014, regarding the choking episode involving resident # 200 and the current care plan, which lacked clear direction.
The resident's care plan was updated on March 13, 2014. The choking risk and interventions were now identified however, the plan did not identify resident # 200's behavioural responses during meals or interventions to manage the responses.
The licensee did not ensure that resident # 200 was protected from neglect. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall develop and implement processes to ensure an immediate investigation is commenced after receiving a report of every alleged, suspected or witnessed incident of abuse that is reported to the licensee.

Grounds / Motifs :

1. Resident # 200 had a choking incident while eating a meal. The resident's respiratory condition worsened and the resident was admitted into hospital. Staff # 100 provided the Administrator and DOC, a copy of a written letter of concern (written by resident # 100) regarding neglect of resident # 200. (Inspector # 543 received a copy of this letter on March 12/14) This letter identified that the Registered staff was not supervising residents while they ate (as per Registered staff routine) but was at the desk on the phone. The letter further describes, that the Registered staff failed to immediately assist resident # 200 when the resident choked.
The letter also identified, that a second Registered staff (staff # 102) who was asked to assist, was uncertain how to use the suction machine and that another suction machine from a different area was used to suction the resident. (the first suction machine was functional at the time of the incident) In discussion with the home's educator, Staff # 103 identified to Inspector # 543, that education related to the suction machine is not routinely provided and that no education regarding use of suction machines was provided post incident.
This allegation of neglect brought forward to the Administrator and DOC in a written letter of concern was not reported to the Director nor was the Director informed of the written letter of concern (complaint).
On March 12, 2014, Inspector # 543 reviewed resident # 200's health care record, which included MDS assessments, progress notes and care plan. Resident # 200's admission nutritional assessment, which would identify a

resident's choking risk or swallowing difficulty, was incomplete.
The progress notes identified that the dietitian did observe resident # 200 eating post choking episode and identified that the resident was at risk of choking. The dietitian identified that there would be no change to the interventions on the care plan. (there were no interventions documented) The dietitian also documented that the resident had behavioural responses during meals, which put the resident and staff at risk of injury.
On March 12, 2014, Inspector # 543 reviewed resident # 200 care plan, which did not identify the resident's choking risk, interventions to manage the choking episodes, the resident's behavioural responses during meals or interventions to manage the responses.
Inspector # 158 and # 543 met with the DOC and the Administrator on March 13, 2014, regarding the choking episode involving resident # 200 and the current care plan, which lacked clear direction.
The resident's care plan was updated on March 13, 2014. The choking risk and interventions were now identified however, the plan did not identify resident # 200's behavioural responses during meals or interventions to manage the responses.
The licensee did not ensure that resident # 200 was protected from neglect. [s. 19. (1)]
(158)

2. According to a Critical Incident, resident # 203 approached staff # 111 and staff # 112, requesting assistance for another resident. Resident # 203 later re-approached staff # 111 in the dining room identifying that it had been 30 minutes and assistance had not been provided. Staff # 111 responded to resident # 203, in the presence of residents and staff, in an elevated voice, described by staff as "screaming and barking" at the resident.
In an interview with Inspector # 544 on March 10, 2014, the DOC identified that resident # 203 reported the incident of neglect and verbal abuse to them and that a complaint investigation was initiated. The DOC confirmed that no staff member had reported the neglect or verbal abuse incident to the Administrator, DOC or Charge Nurse.
Inspector # 158 reviewed the home's policy titled Resident Rights, Care, and Services – Abuse (2558- 2563), which identified that "suspected and or confirmed allegations of abuse shall be reported immediately to the Administrator, DOC, if the Administrator is not in the home or to the Charge Nurse, if the DOC is not in the home; that a Critical Incident Report is to be initiated when an alleged incident of abuse is reported and that the alleged

abuser would be off with pay pending investigation of the incident.
A Critical Incident regarding staff to resident verbal abuse was reported to the Director, however, it was not immediately reported, as required.
A copy of staff # 111's discipline, identified that a meeting to discuss verbal abuse toward the resident was held with the administrator and staff # 111. The Critical Incident identified that a second disciplinary meeting with the DOC was held 11 days later. According to the staffing schedule, Inspector # 158 noted that staff # 111 was scheduled to work 4 days during the investigation. The DOC confirmed that according to staff # 111 time cards, staff # 111 did work those days during the investigation.
The Licensee failed to protect residents, in particular resident # 203 and another resident from abuse through a pattern of inaction and/or inappropriate and/or insufficient action. [s. 19. (1)]
(158)

3. During the resident interviews, it was identified by resident # 7978, resident # 7967 and resident # 8023, that staff # 113 was rude, abrupt, loud and disrespectful to residents (especially residents who are cognitively impaired) residing in one area of the home.
Inspector # 544 spoke with the 3 residents on March 10, 2014 and they re-confirmed the allegation of verbal abuse.
On March 10, 2014, Inspector # 544 spoke to the DOC regarding the allegations of verbal abuse made about staff # 113. The DOC identified that staff # 113 was disciplined for previous instances of verbal and emotional abuse of residents.
Staff # 113's employee file, which was reviewed by Inspector # 544 contained letters showing progressive discipline and actions to prevent further abuse.
Inspector # 158 reviewed the home's policy titled Resident Rights, Care, and Services – Abuse (2558- 2563) which identified that a Critical Incident Report is to be initiated when an alleged incident of abuse is reported and that the alleged abuser would be off with pay pending investigation of the incident. It is further identified that when abuse has been validated, a staff member may be disciplined with an oral reminder, written warning, suspension or terminated.
Inspector # 158 reviewed the CI regarding the above allegation. The information in the CI report did not reflect what Inspector # 544 had conveyed to the DOC on March 10, 2014. The CI report instead contained information that Inspectors # 158 and 543 had conveyed to the DOC on March 12, 2014.
The Critical Incident Report identified the home's long-term actions,however, these were the same actions identified in staff # 113 last discipline.
The Licensee failed to protect residents, in particular resident # 7978, # 7967

and # 8023, from abuse through a pattern of inaction and/or inappropriate and/or insufficient action.
(158)

4. The licensee failed to protect residents from abuse by anyone and did not ensure that residents are not neglected by the licensee or staff.
Two Critical Incidents, both regarding staff to resident verbal abuse by staff # 114, were reported to the Director at two separate times on the same day. It was identified in the first Critical Incident that staff # 121 heard staff # 114 verbally abusing resident # 204. A second incident of verbal abuse by staff # 114 occurred two hours later, when staff # 120 heard staff # 114 say to resident # 205 "we all have a job to do, so leave us alone".
Inspector # 158 spoke with the DOC on March 20, 2014 regarding the information provided in the Critical Incidents. The DOC clarified the following:
- that staff # 121 alluded to the incident of the first verbal abuse at the managers' meeting
- that No action was taken regarding the abuse incident until both staff # 121 and staff # 120 came forward two hours after the second abuse occurred and after the managers' meeting
- that the staff could have reported the incidents immediately to anyone (i.e administrator), but had not.
The DOC identified that staff # 114 was approached after their lunch and then sent home.
Inspector # 158 reviewed the home's policy titled Resident Rights, Care, and Services Abuse (2558- 2563) which identified that "suspected and or confirmed allegations of abuse shall be reported immediately to the Administrator, DOC if the Administrator is not in the home or to the Charge Nurse if the DOC is not in the home and that the "abuser" would be removed from the situation and placed off work with pay pending the investigation of the incident". As confirmed by the DOC, the home's abuse policy was not followed.
The Licensee failed to protect residents, in particular resident # 204 and resident # 205, from abuse through a pattern of inaction and/or inappropriate and/or insufficient action. (158)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 2014

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

Ministère 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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of April, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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