Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2018	2017_418615_0028	021965-17	Resident Quality Inspection

Licensee/Titulaire de permis

FIDDICK'S NURSING HOME LIMITED
437 FIRST AVENUE P.O. BOX 340 PETROLIA ON N0N 1R0

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

FIDDICK'S NURSING HOME
437 FIRST AVENUE P.O. BOX 340 PETROLIA ON N0N 1R0

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

HELENE DESABRAIS (615), CAROLEE MILLINER (144), INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 16, 17, 18, 19 and 20, 2017.

The following inspections were conducted during the Resident Quality Inspection:

Director Order follow-up Log# 008476-17 related to non-allowable resident charges;
Complaint IL-47804-LO/Log# 031880-16 related to medication administration;
Complaint IL-46936-LO/Log# 028653-16 related to alleged abuse/neglect of a resident;
Complaint IL-53022-LO/Log# 022402-17 related to alleged abuse/neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Assistant Director of Resident Care (ADRC), a Registered Practical Nurse-Resident Assessment Instrument Coordinator (RPN-RAI Coordinator), an Executive Assistant, a Rehabilitation Coordinator, a Food Service Supervisor, an activity staff, a housekeeping staff, six Registered Practical Nurses (RPNs), 10 Personal Support Workers (PSWs), the Family Council representative and over 20 residents.

During the course of the inspection, the inspector(s) also toured the resident home areas and common areas, medication rooms, observed resident care provision, resident and staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **7 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. 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:
9. Every resident has the right to have his or her participation in decision-making respected. 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 has failed to ensure that residents' right to have his or her participation in decision-making were fully respected and promoted.

During stage one of the RQI, a resident was asked if they were involved in decisions about the care they received. The resident responded they have used a specific device for years and when admitted to the home they were told the Ministry of Health did not allow that device to be used and it was taken away. The resident said they preferred to use their specific device.

A review of the home's policy stated that the specific devices "are permitted in the facility".

A review of the resident’s clinical record from the date of admission to the home to present date did not include the residents’ preference to use the specific device.

A review of the resident's clinical record stated that the resident was assessed as having borderline intact cognitive abilities.

A review of the resident’s care plan indicated that they required little or no assistance with care when using the specific device and an assessment identified that they required limited assistance of one staff when not using the specific device.

During an interview, an RPN and two PSWs said that the resident was independent with the specific device before the home’s policy was amended to exclude the specific device but now needed assistance for safety when using a different device.

During an interview, the DRC explained the home’s policy had been amended to exclude the specific device for infection prevention control reasons as staff were not able to provide the time required to clean the device and safety reasons for the residents. The DRC stated that a RPN on the unit spoke with the resident about the risks with their specific device and why the policy needed to be changed; that there were no discussions with the resident other than other devices' options. When asked, the DRC was unable to provide examples of past incidents with residents related to the use of the specific device.

During an interview, another resident told a different inspector that they were told by staff, for no apparent reasons, that they could not have the specific device and when asked what they preferred and wanted, the resident stated that they wanted their specific device to be independent.

During an interview, the Administrator stated that the home's policy related to the device was amended for infection control reasons and residents' safety and that in this case, permit the resident to use the specific device was not manageable and "would result in a domino effect with other residents". The administrator was unable to provide examples of past incidents related to resident use of the specific device and added that this issue was not related to resident rights and that the home would not deviate from their practice. The DRC shared during this interview that the home could not see their way to permitting residents to use the specific device.

The licensee failed to ensure that two residents' right to have his or her participation in

decision-making were fully respected and promoted. [s. 3. (1) 9.]

2. The licensee has failed to ensure that every resident has the right to 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.

On a specific date an Inspector observed the computer on the medication cart in a corridor with the PCC software program opened to the clinical record for a specific resident. Residents were walking in the area. A RPN was in a resident's room with the door ajar during the observation. The RPN told the Inspector that the PCC program should be closed on the medication cart when the cart was left unattended.

On a specific date in a different resident home area the Inspector and a PSW observed the computer at the desk area opened to the PCC software program and revealing the clinical record for a specific resident. Residents were walking in the area. The PSW told the Inspector that the RPN had gone for their break. The RPN on return to the desk, told the Inspector they had been called away from the desk and had forgotten to close the PCC program. The RPN further stated that the PCC program should be closed when the desk area was left unattended.

During an interview, the DRC acknowledged that the personal health information of residents should have been kept confidential and that the PCC program should have been closed in both of the above situations.

The licensee has failed to ensure that every resident had his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' right to have his or her participation in decision-making fully respected and promoted, and to ensure that every resident has the right to 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A) A review of a resident's clinical record indicated the resident was at high nutritional risk related to their diagnosis and the physician's orders and care plan interventions were specific to their diagnosis.

A review of the kardex task record on Point of Care for the resident indicated that staff

were to document what had to be provided to the resident and also options available to indicate if the resident refused what was provided.

A review of the resident's clinical documentation for a specific period indicated that there were instances where no documentation occurred.

B) A review of a different resident's clinical record indicated the resident was at nutritional risk related to their diagnosis and the physician's orders and care plan interventions were specific to their diagnosis and options available to indicate if the resident refused what was provided.

A review of this resident clinical documentation for a specific period also indicated that there were instances where no documentation occurred.

During an interview, a Food Service Manager the DRC acknowledged that documentation was missing for the two residents and that the expectation was that PSWs were to document what was offered to the resident so that the effectiveness of the interventions could be assessed.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented. [s. 6. (9) 1.]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of resident's assessment on a specific date stated that the resident was experiencing pain to a specific area of their body. The resident's care plan indicated that the resident was experiencing pain to a different part of their body.

During interviews, a RPN stated that the resident was receiving analgesic on a daily basis for pain and the RPN and a PSW stated that resident had pain to a different specific area at times and nowhere else.

During an interview, the DRC stated that the home's expectation was that resident's care plan should be reflecting the current care needs of the resident.

The licensee has failed to ensure that the resident was reassessed and the plan of care

was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was compliance history of this legislation being issued in the home, January 9, 2017 as a Voluntary Plan of Correction (VPC) on a on a Resident Quality Inspection # 2017_532590_0002 and on September 16, 2015 as a Written Notification (WN) on a Critical Incident Inspection # 2015_216144_0052. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of care set out in the plan of care is documented, and to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and residents were not neglected by the licensee or staff in the home.

A Complaint was made on a specific date to the Ministry of Health and Long-Term Care (MOHLTC) related to alleged abuse from staff to a resident.

Section 2 (1) of the Ontario Regulation 79/10 defines “emotional abuse” as "(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or (b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.”

“verbal abuse” means, "(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

A review of the home's Policy and Procedures Abuse and Neglect #G-101, dated July 2016, stated in part: "Emotional Abuse is defined as: Any action or behaviours that may diminish the sense of identity, dignity and self-worth of a resident; stress or distress caused by abuse; threatening or insulting gestures, behaviour or language; imposed social isolation including "shunning", ignoring, or lack of acknowledgement; the denial or deprivation of any of a resident's rights as set out in the Resident's Bill of Rights." "Verbal Abuse is defined as: swearing; name calling, cultural or racial slurs; threats or insults; shouting; belittling, degradation, infantilization; sarcasm, teasing, taunting; intimidation; inappropriate tone of voice and manner of speaking which is upsetting and or frightening to the resident".

A review of the resident's current care plan and progress notes stated in part that the resident had inappropriate behavior and was resistive to care. On a specific date the resident said they felt they were being harassed every day to complete a task and staff notified the Administrator.

During an interview, the resident stated that since their admission, they had been forced or coerced in completing a task and that the Administrator had been yelling, harassing and threatening them to comply if not, there would be consequences.

During an interview, a PSW stated that they overheard the Administrator threatening the resident of consequences if they did not comply with the task. When asked if they felt it

was abuse the PSW said "yes and thought management would call the Ministry".

During an interview, a different PSW said that the resident did not like completing the task. The PSW said the resident required a lot of encouragement and a lot of interactions because the resident has a specific diagnosis and staff don't understand that, they don't know how to deal with that. The PSW shared that they only knew that the Administrator would come and talk with the resident about completing the task.

During an interview, an Activity Staff stated that they often work on the resident's floor and on many occasions have heard the Administrator yelling at the resident. The Activity Staff said that the Administrator had asked the resident's roommate to get out of the room so they could talk with the resident behind closed door and stated that staff were aware about the incidents and should of been reported to the Ministry.

During an interview with the resident's roommate, they stated that they have been in the same room for a while and that the issue about completing the task was difficult and that the Administrator was coming in the room and talked loud to the resident.

During an interview, a RPN said that the resident was not completing the task prior to their admission and the Administrator got involved and made an agreement with the resident that if they completed the task a specific number of times per week, they would be able to get what they have been asking for. The RPN stated that they have heard the yelling between the Administrator and the resident and when asked if this was abuse the RPN stated "yes, it was abuse".

During an interview with the Administrator and the DRC, the Administrator stated that they "bargained" with the resident that if the resident completed the task three times a week they would provide what the resident wanted, a reward. The Administrator said that if the resident did not complete the task that the reward would be taken away. The Administrator and the DRC stated that the resident had a specific diagnosis that staff were not trained to “deal” with that diagnosis. Furthermore, the Administrator stated that they had "raised" their voice with the resident "but has not yelled at them".

The Administrator added that they had several chats with the resident to complete the task and the resident thought their insistence was wrong.

The licensee has failed to ensure that the resident was protected from abuse by anyone and residents were not neglected by the licensee or staff in the home.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was compliance history of this legislation being issued in the home, on May 17, 2016 as a Voluntary Plan of Correction in Inspection #2016_257518_0020. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and residents are not neglected by the licensee or staff in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area of the medication cart that was secured and locked.

On a specific date, an Inspector observed the medication cart in a corridor unlocked and unattended. Residents were walking in the area. The Inspector also observed a medication cup on the medication cart containing one white, one pink and one purple pill. The RPN remained in a resident's room with the door ajar during the observation.

During an interview, the RPN told the Inspector that they had left the medication cart unlocked with the three medications for a resident on the top of the cart. The RPN identified the medication classifications as one vitamin pill and two heart related medications, acknowledged that they were not able to see the medication cart from inside the room with the door ajar and that the medication cart should have been locked and medications should not have been left on the top of the medication cart when they entered the room.

During an interview, the DRC stated that the medication cart should not have been left unlocked and that medications should not have been left on top of the medication cart unattended.

The licensee has failed to ensure that drugs were stored in an area of the medication cart that was secured and locked.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area of the medication cart that is secured and locked, 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A review of a Medication Incident Report, on a specific date, and the clinical record for a resident revealed that the incident of a medication omission was not reported to a resident's substitute decision-maker (SDM) if any, the Medical Director (MD), the attending physician, the pharmacy service provider and the prescriber of the drug.

A review of a different Medication Incident Report and the clinical record for a resident revealed the incident of the resident receiving medications that were not prescribed for them by a physician, was not reported to the MD, the pharmacy service provider and the prescriber of the drug.

A review of a third Medication Incident Report and the clinical record for a different resident revealed that the incident of a medication omission was not reported to a resident's SDM if any, the MD, the attending physician and the pharmacy service provider.

During an interview, the DRC stated that the medication omission incidents at the home have never been reported to the resident, the residents' SDM, the Medical Director, the attending physician, the pharmacy service provider and the prescriber of the drug. The DRC acknowledged that they understood the ministry requirements related to this issue and that in the future, medication incidents and medication omissions will be reported as required.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident, the residents' SDM if any, the MD, the attending physician, the pharmacy service provider and the prescriber of the drug.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be widespread during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident who demonstrated responsive behaviours (a) the behavioural triggers for the resident were identified, (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A Complaint was made on specific date to the Ministry of Health and Long-Term Care (MOHLTC) related to alleged abuse of a staff to a resident.

A resident was admitted to the home with a specific diagnosis.

A review of the home's "Policy and Procedures - Behavior Supports Program" dated September 2017, stated in part: "Procedures: A member of the management team (or delegate) will initiate tracking and/or assessments to the Registered Team Member (RTM). This will include a summary of what has occurred and what interventions or assessments have been initiated. The RTM will use education, assessment tools, medication reviews (etc) to address the responsive behaviours with the staff, residents and families. The RTM (or delegate) completes the BSO Resident Roadmap and the behaviour Assessment working through problem solving utilizing the PIECES framework. The RTM enters successful interventions in the resident care plan and completes a summary of effective and ineffective strategies.The RTM follows up to ensure continued effectiveness and monitors for re-evaluation.", and "The internal BSO Team and/or physician will initiate a referral to the external LHIN BSO Team when required".

A review of the resident's current care plan and progress notes stated in part that the resident had inappropriate behavior and was resistive to care. On a specific date the resident said they felt being harassed every day to complete a task and staff notified the Administrator.

During an interview, the resident stated that since their admission, they had been forced or coerced in completing a task and that the Administrator had been yelling, harassing and threatening them to comply if not, there would be consequences.

During an interview, a PSW stated that the task was to be completed every day. When the PSW asked for what reason they said that they did not know why and stated that they overheard the Administrator threatening the resident to take away their reward if the resident did not complete the task.

During an interview, a PSW said that the resident did not like to complete the task and they required a lot of encouragement and a lot of interactions because the resident had that specific diagnosis and staff did not understand that, “they don't know how to deal with that”. The PSW stated that the resident needed to complete the task a number of times per week. The PSW shared that they only knew that the Administrator would come and talk with the resident about completing the task when they refused.

During an interview with the resident's roommate, they stated that they have been in the

same room for a while and that the issue about completing the task was was difficult and that the Administrator was coming in the room and talked loud to the resident.

During an interview, a RPN stated that the Administrator got involved and made an agreement with the resident that if they completed the task they would be rewarded with what they wanted.

During an interview with the Administrator, the DRC and two inspectors, the Administrator stated that they "bargained" with the resident that if the resident completed the task a specific number of times a week they would reward the resident with what the resident liked and that if the resident did not complete the task the reward would be taken away. The Administrator and the DRC stated that the resident has a specific diagnosis and stated that the resident was currently being seen by the internal BSO team. They also added that staff were not trained to "deal" with that specific diagnosis.

The Administrator added that some staff were able to "coax the resident" to complete the task; that they "bargained with the resident" that if the resident completed the task they would be rewarded and that "girls were intimidated by the resident".

During a telephone interview, on a specific date, the DRC said that the resident was assessed by an external agency because "they are above BSO", when asked if the resident was assessed by the home's BSO team for their behaviours, the DRC repeated that the external agency assessed the resident and the resident had a PSW with them when they had behaviours and was monitored. The inspector requested the DRC to fax to the MOHLTC a copy of the home's policy for responsive behaviours and responsive behaviours assessment.

A review of the resident's external agency assessment stated in part that the resident had behaviour escalation on a specific date, and included specific interventions for the resident.

During a second telephone interview, the DRC was asked to provide the resident's internal or external BSO assessments which would include the triggers of the behaviours, the planning, interventions and evaluation, the DRC could not provide this information. No other assessments for responsive behaviours were provided.

The licensee has failed to ensure that for the resident who was demonstrating responsive behaviours (a) the behavioural triggers for the resident are identified, (b) strategies are

developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 53. (4)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 151. Obstruction, etc.
Every person is guilty of an offence who,
(a) hinders, obstructs or interferes with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties;
(b) destroys or alters a record or other thing that has been demanded under clause 147 (1) (c); or
(c) fails to do anything required under subsection 147 (3). 2007, c. 8, s. 151.

Findings/Faits saillants :

1. The licensee has failed to ensure that they did not, hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impede an inspector in carrying out his or her duties.

Section 149 (1) of the Long-Term Care Homes Act, 2007 states "After completing an inspection, an inspector shall prepare an inspection report and give a copy of the report to the licensee and to the Residents' Council and the Family Council, if any".

A review of the Ontario Admin Handbook policy "Public Reporting", dated August 23, 2017, stated: "The Administrative Assistant (AA) opens the memo template for distribution to the Administrator, Residents' Council and Family Council and fills in the date, Inspection #, Report Date, and Inspection Type. The AA attaches the memo to the front of each copy of the public report(s). The public report(s) with the completed memo

is placed into a separate sealed envelope addressed to the:
a. Administrator;
b. President, Residents’ Council; and
c. President, Family Council.
Place all three sealed envelopes into a courier package".
The memo attached to package stated "Individual envelopes addressed to the ‘President, Residents’ Council’, and ‘President, Family Council’, must be distributed, unopened to the addressee" and "A copy of the Inspection Report-AMENDED Public Copy must be made available without charge upon request."

During an interview, on a specific date, the Family Council President returned the Family Council Questionnaire to the inspector and stated that they had asked the home to have a copy of the public inspection report in the past and never heard from them. The Family Council questionnaire completed by the President of the Council stated: "Had access to reports posted on board but do not have copy exclusively for Family Council".

During an interview, the Administrator stated that they had received the inspection reports and a copies for the Residents' Council and Family Council. The Administrator said that the copies were given to the Activity Director and was reviewed during the Councils meetings. The Activity Director stated that they did not given the copies to the Councils because they were told not to, a long time ago, by the previous Activity Director.

During interviews, the Administrator stated twice that they had "a problem" giving a copy of the public report to the Councils because they "don't want that to go on the air".

The licensee has failed to ensure that they did not, hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impede an inspector in carrying out his or her duties by not giving a copy of the inspection report to the Residents' Council and the Family Council.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 151. (a)]

Issued on this 2nd day of February, 2018

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

Original report signed by the inspector.