Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 17, 2016	2016_293554_0010	006153-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

FOSTERBROOKE
330 KING STREET WEST NEWCASTLE ON L1B 1G9

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 31, June 01-03, and June 07-08, 2016.

The following intakes were reviewed and inspected upon during this inspection, #006153-16, #009272-16, #012077-16, #013912-16, and #015981-16.

Summary of Intakes:
1) #006153-16 – Complaint regarding activation within the home, specific to first floor resident home area;
2) #009272-16 – Complaint regarding short staffing and responsive behaviours,

specific to resident #003;
3) #012077-16 – Complaint regarding responsive behaviours, specific to resident #003;
4) #013912-16 – Complaint regarding inappropriate lifts and transfers, during resident care;
5) #015981-16 – Complaint regarding a registered nursing staff not following the home's bowel protocol policy and procedure.

Evidence for non-compliance, relating to intake #015787-16, specific to LTCHA, 2007, s. 24 (1) and O. Reg. 79/10, s. 54 (b), is captured in inspection report #2016_293554_0011, which was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Acting Director of Care, Associate Director of Care, Office Manager, Nutrition Manager, RAI-Coordinator, Physician, Pharmacy Consultant, Regional Director, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aides, Physiotherapist, and Residents.

During the course of this inspection, the inspector reviewed clinical health records for active and deceased residents, observed resident to resident interactions, observed resident to staff interactions, observed lift and transfer techniques, reviewed home's investigations specific to identified intake-complaints, reviewed Complaint Log Binder 2015-2016, reviewed home specific policies and procedures, specifically, Resident Non-Abuse, Dementia Care, Management of Concerns, Complaints and Compliments, No Manual Lift-Standard Operating Procedure, Safety In Ambulating, Lifting and Transfer Program, Falls Interventions Risk Management Program, S.A.L.T. Safety in Ambulating , Lifting and Transferring, Continence Care, Bowel Protocols for Prevention of Constipation, Point Click Care eMAR Quick Facts, Medication Administration, Admission Orders-Bowel Protocols, PRN Medication Administration and Documentation, Interdisciplinary Documentation, Psychotropic Medications; and reviewed Physician Advisory Committee Meeting Minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

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

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1), by not ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident: the goals the care is intended to achieve; and clear direction to staff and others who provide direct care to the resident, specifically as it relates to safe-guarding residents from abuse of another resident.

Related to Intake #012077-16, for Resident #012:

Resident #012 has a history that includes, cognitive and physical limitations. Registered Nurse #032, and the Associate Director of Care, all indicated that resident is dependent on staff for activities of daily living and has limited verbalization skills. Resident #012 shares a room with resident #003.

The clinical health record for resident #012 was reviewed for the period of five months and indicated the following:

- On an identified date – Personal Support Worker indicated to Registered Nurse that during a specific shift times resident would not get up to go to the washroom and will not ring his/her call bell. Personal Support Worker reported resident #012 appeared frightened. When staff asked resident what was wrong he/she verbalized he/she was scared. Registered Nurse, who was in the charge nurse role, indicated in the progress note that written documentation has been forwarded to the Executive Director, specific to resident being fearful.
- On an identified date - Resident was hesitant about going into his/her room, which is shared by three other residents. When resident entered room, accompanied by staff, resident looked over at resident #003; resident eventually went into his/her bed and settled for the night.

Personal Support Worker #029, and #036, as well as Registered Practical Nurse #034 and Registered Nurse #032 all indicated resident #012 was fearful of resident #003 and was hesitant on entering his/her room to use the washroom or settle to bed at night. Staff interviewed indicated resident #003 was frequently heard exhibiting specific responsive behaviours towards resident #012. Personal Support Workers indicated they reported their concerns and resident #012's fear to the Associate Director of Care and to the Executive Director.

The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged awareness of resident #012 being fearful of resident #003.

The written plan of care, for resident #012, was reviewed and failed to provide documentation to support that there was any planned care, goals the care is intended to achieve, and or clear direction to staff and others who provide direct care to the resident, specifically as it relates to safe-guarding resident #012 from the alleged verbal/emotional abuse of resident #003. [s. 6. (1)]

2. Related to Intake #012077-16, for Resident #011:

Resident #011 shares a room with three co-residents, one of which is resident #003. Resident #011 indicated that he/she was fearful of resident #003. Resident #011 stated resident #003 often exhibits a specific responsive behaviour towards him/her for snoring or getting up to use the washroom in the night; resident #011 commented that he/she often slept in the basement to keep away from resident #003, resident indicated resident #003 was a dangerous person.

The clinical health record for resident #011 was reviewed for the period of five months; the review provided documentation of the following:

- On an identified date – Resident #011 was found sleeping in the basement in a chair; resident stated that resident #003 was exhibiting identified responsive behaviours at him/her.
- On an identified date – Resident was up at a specified hour, stated resident #03 was exhibiting identified responsive behaviours towards him/her; resident indicated he/she was going to the basement to sleep.
- On an identified date – Resident was up at a specified hour and reported that resident #003 was exhibiting identified responsive behaviours towards him/her. Resident went to the Harvest Room to sleep for the night.
- On an identified date – Reported that resident #003 was exhibiting a specific responsive behaviour towards him/her during an planned group bus trip; resident indicated he/she was very embarrassed and said he/she was upset about the incident.
-There are an additional ten entries which document resident sleeping in the Harvest Room, which is located in the basement.

Personal Support Worker #029, and #036, as well as Registered Practical Nurse #034 and Registered Nurse #032 all indicated resident #011 was fearful of resident #003. Staff

indicated resident #011 was afraid to sleep in his/her own bed and would often sleep in the basement and or go to his/her family's home to sleep. Personal Support Workers #029 and #36 indicated resident #003 would frequently exhibit specific responsive behaviours towards resident #011. Personal Support Workers indicated they reported their concerns and resident #011's fear to the Associate Director of Care and to the Executive Director.

The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged awareness of resident #011 being fearful of resident #003.

The written plan of care, for resident #011, was reviewed and failed to provide documentation to support that there was any planned care, goals the care is intended to achieve, and or clear direction to staff and others who provide direct care to the resident, specifically as it relates to safe-guarding resident #011 from the alleged verbal/emotional abuse of resident #003. [s. 6. (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 there is a process in place and monitored to ensure there is a written plan of care for each resident that sets out, the planned care for the resident: the goals the care is intended to achieve; and clear direction to staff and others who provide direct care to the resident, specifically as it relates to safe-guarding residents from abuse of another resident, as such is required, to be implemented voluntarily.

WN #2: 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. The licensee failed to comply with LTCHA, 2007, s. 22 (1), by not ensuring written complaints concerning the care of a resident or the operations of the long-term care home was forwarded to the Director.

Related to Intake #006153-16:

The Recreation Manager received a written complaint, from a concerned staff who wished to remain anonymous, on an identified date with regards to activation programming not being provided to all residents in the long-term care home, especially those residing on a specific resident home area.

The Recreation Manager, as well as the Executive Director, both indicated the letter was not forwarded to the Director.

2. Related to Intake #015981-16:

A written correspondence, for two identified dates, was received by the Acting Director of Care. The written correspondence indicated that Registered Practical Nurse #034 was not following the home's bowel management protocol, specifically as it related to residents not having a bowel movement in four to five days; the written correspondence further alleged that Registered Practical Nurse #034 was making false entries in resident health care records.

The Acting Director of Care, as well as the Executive Director, both indicated that the written complaint was not forwarded to the Director. [s. 22. (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 there is a process in place and monitored to ensure written complaints concerning the care of a resident or the operations of the long-term care home was forwarded to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, s. 23 (1) (a), by not ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated.

Related to Intake #012077-16, for Resident #012:

A review of the clinical health record, for resident #012, for a period of five months, provides documentation of two occasions in which resident was fearful entering his/her room or calling for assistance to use the washroom.

Personal Support Worker #029, and #036, as well as Registered Practical Nurse #034 and Registered Nurse #032 all indicated resident #012 was fearful of resident #003 and was hesitant on entering his/her room to use the washroom or to settle into bed at night. Staff interviewed indicated resident #003 was frequently heard exhibiting a specific responsive behaviour towards resident #012. Staff indicated that their concerns were reported to the Associate Director of Care and the Executive Director.

The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged that a resident exhibiting specific responsive behaviours towards another resident would be considered verbal abuse; all acknowledged being advised by nursing staff that resident #012 was fearful of resident #003.

The Executive Director indicated that the allegations of verbal and emotional abuse by resident #003 towards resident #012 were not investigated as resident #012 is unable to verbalize his/her feelings. [s. 23. (1) (a) (i)]

2. Related to Intake #012077-16, for Resident #011:

Resident #011 indicated that he/she was fearful of resident #003. Resident #011 stated resident #003 often exhibits specific responsive behaviours towards him/her for snoring or getting up to use the washroom in the night; resident #011 commented that he/she often slept in the basement to keep away from resident #003, resident indicated resident #003 was a dangerous person. Resident #011 indicated that he/she reported his/her concerns to personal support workers, a Registered Nurse and the Associate Director of Care.

A review of the clinical health record, for resident #011, for a period of five months provides documentation of four incidents of which resident #011 reported being the recipient of responsive behaviours exhibited by resident #003; and ten other occasions documented indicating resident #011 slept in the basement versus in his/her own room.

Clinical health record documentation provides supporting evidence that registered nursing staff were aware of incident on four separate incidents in which resident #011 reported that resident #003 was exhibiting specific responsive behaviours towards resident #011.

The Associate Director of Care, Acting Director of Care and the Executive Director all

acknowledged awareness of resident #011 being fearful of resident #003. The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged that a resident exhibiting specific responsive behaviours towards another resident would be considered verbal-emotional abuse.

The Executive Director indicated that the allegations of verbal and emotional abuse by resident #003 towards resident #011 were not investigated as resident #011 tends to tell stories, and she couldn't be certain what resident #011 was saying was correct. [s. 23. (1) (a) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is a process in place and monitored to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring a person who had reasonable grounds to suspect that any of the following has occurred, or may occur immediately report the suspicion and the information upon which it was based to the Director, specifically as it relates to abuse of a resident by anyone.

Related to Intake #012077-16, for Resident #012:

The clinical health record, for resident #012, was reviewed for a period of five months; the following was documented by registered nursing staff:

- On an identified date - Resident was hesitant about going into his/her room, which is shared by three other residents. When resident entered room, accompanied by staff, resident looked over at resident #003; resident eventually went into his/her bed and settled for the night.
-On an identified date – Personal Support Worker indicted to Registered Nurse that during the night resident would not get up to go to the washroom during the night and will not ring his/her call bell; staff reported resident appeared frightened. When staff asked resident what was wrong he/she verbalized he/she was scared. Registered Nurse, who was in the charge nurse role, indicated in the progress note that written documentation has been forwarded to the Executive Director, specific to resident being fearful.

Registered Nurse #035, who is a charge nurse, indicated in the progress notes, that the concerns of resident #012 were reported to the Executive Director. There is no indication that Registered Nurse #035 reported the allegations of abuse to the Director (Ministry of Health and Long-Term Care).

Personal Support Worker #029, and #036, as well as Registered Practical Nurse #034 and Registered Nurse #032 all indicated resident #012 was fearful of resident #003 and was hesitant on entering his/her room to use the washroom or settle to bed at night. Staff interviewed indicated resident #003 was frequently heard exhibiting specified responsive behaviours towards resident #012. Personal Support Workers indicated they reported their concerns to the Associate Director of Care and the Executive Director.

The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged awareness of resident #012 being fearful of resident #003. The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged

that a resident exhibiting specific responsive behaviours towards another resident would be considered verbal/emotional abuse.

Associate Director of Care, Acting Director of Care and the Executive Director all indicated the allegations of resident to resident verbal/emotional abuse, which was alleged to be occurring, specifically as reported by staff on specific dates, were not reported to the Director. The Executive Director indicated that she was not able to confirm that resident #012 was fearful of resident #012 as he/she is unable to verbalize his/her feelings, therefore she did not report such as abuse. [s. 24. (1) 2.]

2. Related Intake ##012077-16 to Resident #011:

Resident #011 indicated that he/she was fearful of resident #003. Resident #011 stated resident #003 often exhibits specific responsive behaviours towards him/her for snoring or getting up to use the washroom in the night; resident #011 commented that he/she often slept in the basement to keep away from resident #003, resident indicated resident #003 was a dangerous person.

The clinical health record, for resident #011, was reviewed for a period of five months; the following was documented by registered nursing staff:

- On an identified date– Resident found sleeping in the basement in a chair; resident stated that resident #003 was exhibiting specific responsive behaviours towards him/her.
- On an identified date – Resident was up at a specific hour, stated resident #003 was exhibiting specific responsive behaviours towards him/her; resident indicated he/she was going to the basement to sleep.
- On an identified date – Resident was up at a specific hour and reported that resident #003 was exhibiting a specific responsive behaviour towards him/her. Resident went to the Harvest Room to sleep for the night.
- On an identified date – Reported that resident #003 exhibited a specific responsive behaviour towards him/her during a scheduled group bus trip; resident indicated he/she was very embarrassed and said he/she was upset about the incident.
- There are an additional ten entries which document resident sleeping in the Harvest Room, which is located in the basement; all of which relate to resident #011 being fearful of resident #003. Resident #011 indicated he/she slept in the basement to avoid responsive behaviours exhibited by resident #003 towards him/her.

The Registered Nurse #035 indicated in progress notes, that the concerns of resident

#011 were reported to the Executive Director. There is no indication that Registered Nurse #035 reported the allegations of abuse to the Director (Ministry of Health and Long-Term Care).

The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged awareness of resident #011 being fearful of resident #003. The Associate Director of Care, Acting Director of Care and the Executive Director all acknowledged that a resident exhibiting specific responsive behaviours towards another resident would be considered verbal abuse.

Associate Director of Care, Acting Director of Care and the Executive Director all indicated the allegations of resident to resident verbal/emotional abuse, which were said to have occurred on four separate incidents, were not reported to the Director. The Executive Director indicated that she did not report allegations of resident #011 being fearful of resident #003 nor allegations of resident #003 exhibiting specific responsive behaviours towards resident #011 as resident tends to tell stories. [s. 24. (1) 2.]

3. Related to Intake #015787-16:

The health care record for residents #001 and #002 were reviewed for a period of five months.

On a specific date, Registered Practical Nurse #026 heard resident #002 yelling for help, observed a personal support worker removing resident #002 from behind a laundry cart and observed resident #001 standing in front of resident #002's mobility aide and attempting to exhibit an indicated responsive behaviour towards resident #002; resident #001's hat was observed on the floor. Staff intervened, separating the two residents. Following the resident to resident altercation, both residents were assessed; resident #001 was noted by RPN #026 to have sustained an injury as a result of the physical abuse incident.

Registered Practical Nurse #026 indicted that he/she believed this incident was reported to the Acting Director of Care.

The Acting Director of Care and Executive Director both acknowledged being aware of the resident to resident abuse incident, on the day to which the incident happened.

The Acting Director of Care and the Executive Director, both indicated the alleged

physical abuse incident between residents #001 and #002 was not reported to the Director. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring there is a process in place and monitored to ensure a person who had reasonable grounds to suspect that any of the following has occurred, or may occur immediately report the suspicion and the information upon which it was based to the Director, specifically as it relates to abuse of a resident by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 36, by not ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to Intake #013912-16, for Resident #014:

A staff member submitted a written correspondence to the Executive Director on a specific date, alleging that Personal Support Workers #041 and #042 inappropriately transferred/lifted resident #014 during care.

According to the clinical health record resident #014 fell on a specific date, sustained injury resulting from the fall, was transferred to hospital; resident #014 underwent specific treatments while at the hospital and returned to the long-term care home on a specific date. Readmission physician's orders included resident was to be non-weight bearing.

The plan of care, for resident #014, in place at the time of the said incident directs the following:

- position - following identified positioning techniques
- mechanical lift to assist and support identified lower extremity during all transfers
- slider sheet for repositioning
- extensive assistance for turning and repositioning, with two or more staff
- non-weight bearing
- follow identified precautions to avoid immobility complications

The Executive Director confirmed that a written correspondence was received on an identified date, alleging an inappropriate transfer/lift had occurred. The incident was said to have been witnessed by Registered Practical Nurse #034. The Executive Director and Acting Director of Care initiated an investigation regarding the allegation.

The home's investigation included the following:

- Registered Practical Nurse #034 indicated walking into resident #014's room to find resident standing in front of his/her lounge chair, with PSW's #041 and #042 on each side of resident, holding resident's arms. RPN #034 indicated resident #014 was later assessed and found to have no injury as a result of the said transfer/lift.
- Personal Support Worker #042 indicated, in a statement dated on a specific date, that he/she and PSW #041 did not stand resident #014, but that he/she and his/her partner changed resident's incontinent product with resident #014 sitting in the lounge chair. PSW #042 indicated the continence product was slid out from under resident #014, as PSWs rolled resident sideways and reapplied an continence product.

Registered Practical Nurse #034 indicated PSW #041 and #042 should have followed the home's policy and procedures, specific to lifts and transfers and should have done the following:
- obtained a mechanical lift, transferred/lifted resident #014 from the lounge chair to bed, provided incontinence care and either left resident in bed or transferred/lifted back to lounge chair;
- should not have been provided incontinence care in lounge chair and should not have manually transferred resident as resident #014 was non-weight bearing.

Acting Director of Care and the Executive Director indicated that the investigated was concluded and it was found that:
- PSW #042 by him/herself manually transferred/lifted and repositioned resident #014, while performing continence care. The transfer/lift and repositioning, performed by PSW #042, was the not the assessed transfer/lift or positioning required for this resident #014,

who had an unhealed fractured hip.
- PSW #042 failed to follow the home's policy and procedure specific to lifts and transfers of a resident #014, on the said date. [s. 36.]

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 there is a process in place and monitored to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, 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 failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring that for each resident demonstrating responsive behaviours strategies which are developed are implemented to respond to these behaviours.

Related to Resident #013:

Resident #013 has a history that includes cognition impairment. Resident is dependent on nursing staff for all activities of daily living.

Personal Support Workers (PSW) #031, 043, Registered Practical Nurse (RPN) #040 and Registered Nurse (RN) #032 indicated resident #013 exhibits specific responsive behaviours all day and night; staff indicated recently resident's exhibited responsive behaviours tend to vary in pitch and tone. Personal Support Worker #043 and RPN #040 indicated co-residents often voice displeasure regarding resident #013's exhibited responsive behaviours.

The plan of care for resident #013 indicates the following:

- Resident #013 exhibits responsive behaviours as evidenced by cognitive impairment. Interventions include, allow time to process instructions; provide tactile activities and toys; staff is to remove him/her to quiet area by him/herself if they are unable to get him/her to stop exhibiting identified responsive behaviours (as this gets other residents upset); use face to face approach; use short sentences, less than 6 words, for instructions; uses directional cues; if strategies are not working, leave resident & re-approach in 15-20 mins; requires meal immediately upon arrival in dining area.
- A Geriatric Consultant recommendations, completed on a specific date, recommended the following – resident #013 would benefit from a quiet environment; music, such as old hymns may be a comfort for resident; introducing sensory modulation might be helpful; always approach face to face; repeat messages; consider alternating exposure with tactile stimulation through fidget toys, touch quilts, scarves, and folding activities

On May 31, June 01-03 and June 07, 2016, resident #013 was heard exhibiting specific responsive behaviours from the time the inspector arrived to the long-term care home, at 08:00 hours to approximately 16:00 hours daily. Resident #013 was observed using a mobility aide in the main foyer, in the hallway outside of his/her room and in the dining room.

Registered Practical Nurse #040 and Personal Support Worker #038 were heard on a few occasions telling resident #013 that he/she was being too loud and heard telling resident to lower his/her voice. Resident #013 continued to exhibit specific responsive behaviours despite staff asking him/her to lower his/her voice.

Residents were heard shouting at resident #013 to be quiet. One resident indicated being tired of hearing resident #013 from morning to night; the same resident indicated "it doesn't feel like a home with all that noise".

During this inspection, resident #013 was not observed being provided with tactile activities or toys, or music nor was resident taken to a quiet location away from other residents.

The Executive Director indicated it would be expected that nursing and or other staff would implement interventions as planned, especially if a resident is exhibiting a responsive behaviour. [s. 53. (4) (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 ensuring there is a process in place and monitored to ensure that for each resident demonstrating responsive behaviours strategies which are developed are implemented to respond to these behaviours, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 54 (b), by not ensuring that steps to minimize risk of altercations and potentially harmful interactions between and among residents, included, identifying and implementing interventions.

Related to Intake #015787-16, for Resident #001:

Resident #001 has a history which includes cognitive impairment.

Personal Support Workers, Registered Practical Nurse #026 and Registered Nurse #032 all indicated resident #001 exhibits specific responsive behaviours.

Resident #001's clinical health record was reviewed for a period of five months. Progress notes, written by registered nursing staff, document resident #001 exhibited identified responsive behaviours, the majority of which was directed towards co-residents.

According to the progress notes, two of the identified responsive behaviours resulted in resident #001 sustaining injury.

Registered Practical Nurse #026 and Registered Nurse #032 indicated it was difficult to redirect resident #001's attention when resident was exhibiting specific responsive behaviours; both registered nursing staff indicated that the majority of resident #001's exhibited responsive behaviours were directed towards resident #002.

The clinical health record reviewed fails to provide evidence to support that steps were taken to minimize risk of altercations and potentially harmful interactions between and among residents, included, identifying and implementing interventions as evidenced by the following:

- The plan of care reviewed, for a period of five months, detail resident #001 exhibiting approximately twenty-six documented occurrences of exhibited responsive behaviours; the majority of the said incidents involved verbal and or physical altercations between resident #001 and resident #002.
-The plan of care, fails to identify interventions to prevent or decrease contact between resident #001 and the identified co-resident.
-The plan of care (including physician's orders, progress notes and care plan) fails to provide supporting evidence that there was a reassessment of the residents care needs and or alternative strategies developed and or implemented for resident #001.

The Acting Director of Care and the Executive Director indicated that it would be an expectation that the plan of care include interventions to be taken to prevent altercations when a resident is exhibiting specific responsive behaviours towards co-residents; both indicated that when a resident is not responding to planned interventions, registered nursing staff should have contacted the attending physician for direction. [s. 54. (b)]

2. Related to Intake #015787-16, for Resident #002:

Resident #002 has a history which includes cognitive impairment.

Personal Support Workers, Registered Practical Nurse #026 and Registered Nurse #032 all indicated resident #002 exhibits specific responsive behaviours.

Resident #002's clinical health record was reviewed for a period of five months. Progress notes, written by registered nursing staff, document resident #002 exhibited specific responsive behaviours, towards staff and co-residents.

According to the progress notes, two of the exhibited responsive behaviours resulted in resident #001 sustaining injury.

Registered Practical Nurse #026 and Registered Nurse #032 indicated it was difficult to redirect resident #002's attention when resident was exhibiting specific responsive behaviours; both registered nursing staff indicated that the majority of resident #002's exhibited responsive behaviours were directed towards resident #001.

The clinical health record reviewed fails to provide evidence to support that steps were taken to minimize risk of altercations and potentially harmful interactions between and among residents, included, identifying and implementing interventions as evidenced by the following:

- The plan of care reviewed, for a period of five months, detail resident #002 exhibiting approximately nineteen documented occurrences of exhibited responsive behaviours; the majority of the said incidents involved verbal and or physical altercations between resident #002 and the same co-resident.
- Resident #002 was seen by Geriatric Consultant on a identified date; there is no documented evidence to support that resident #002 was reassessed, that new strategies were identified and or implemented nor that secondary referrals were initiated, despite five resident to resident verbal and or physical abuse incidents during a two month period.
- The plan of care, fails to identify interventions to prevent or decrease contact between resident #002 and the identified co-resident.
- The plan of care (including physician's orders, progress notes and care plan) fails to provide supporting evidence that there was a reassessment of the residents care needs

and or alternative strategies developed and or implemented for resident #002.

The Acting Director of Care and the Executive Director indicated that it would be an expectation that the plan of care include interventions to be taken to prevent altercations when a resident is exhibiting specific responsive behaviours towards co-residents; both indicated that when a resident is not responding to planned interventions, registered nursing staff should have contacted the attending physician for direction. [s. 54. (b)]

3. Related to Intake #012077-16:

Resident #003 has some short term cognition impairment. The clinical health record indicates that resident #003 is capable of making his/her own decisions.

Personal Support Workers, Registered Practical Nurse #034 and Registered Nurse #032 all indicated resident #003 exhibits specific responsive behaviours, the majority of which was directed towards his/her roommates, resident's #011, and #012.

Resident #003's clinical health record was reviewed for a period of five months. Progress notes, written by registered nursing staff, document resident #002 exhibited specific responsive behaviours.

Personal Support Workers, Registered Practical Nurse #034, Registered Nurse #32, as well as Associate Director of Care, Acting Director of Care and the Executive Director, all indicated residents #011, and #012 were fearful of resident #003.

A progress note, as well as Registered Nurse #032 indicated it was difficult to redirect resident #003's attention when resident was exhibiting specific responsive behaviours towards staff and or co-residents. Registered Nurse #032, as well as personal support workers interviewed indicated resident #003's exhibited responsive behaviours occurred mostly during the certain shifts, when staff were providing care to resident #012, when roommates were up to use the washroom or when resident #012 entered the shared room.

The plan of care reviewed, for a period of five months, detail resident #002 exhibiting approximately nineteen documented occurrences of responsive behaviours; the majority of the said incidents involved verbal and or physical altercations between resident #003 and the same two co-residents.

The plan of care, directs that during a particular shift personal support workers approach resident's room quietly and speak in a low voice when providing care for co-residents; staff are to use over bed lighting of the resident they are caring for, instead of turning on the main foyer light; this intervention was implemented on a specific date. According to the clinical health records and interviews with personal support workers, and registered nursing staff this planned intervention was ineffective.

The plan of care fails to provide evidence to support that new strategies or interventions have been identified or implemented since an identified date, despite identified responsive behaviours by resident #003 towards co-residents #011 and #012.

The plan of care (including physician's orders, progress notes and care plan) fails to provide supporting evidence that there was a reassessment of the residents care needs and or alternative strategies developed and or implemented for resident #003.

The Acting Director of Care and the Executive Director indicated that it would be an expectation that the plan of care include interventions to be taken to prevent altercations when a resident is exhibiting identified responsive behaviours towards co-residents; both indicated that when a resident is not responding to planned interventions, registered nursing staff should have contacted the attending physician for direction.

Registered Nurse #032, Associate Director of Care and the Executive Director indicated that resident #003's responsive behaviours were triggered by living in a shared environment, and being disturbed during the day or night by roommates receiving care they required by staff. All indicated resident #003's responsive behaviour posed a challenge to the home and were in agreement that such were upsetting to other residents specifically resident #011 and #012, who both were known to be fearful of resident #003. [s. 54. (b)]

Additional Required Actions:

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

WN #8: 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 failed to comply with O. Reg. 79/10, s. 129 (1) (a), by not ensuring that drugs are stored in an area or a medication cart that is secure and locked.

The following was observed during dates of this inspection:

- June 02, 2016 – two medication cups were observed sitting on top of the medication cart in the hallway, which is located on a specific resident home area. One medication cup contained yellowish liquid, one with whitish substance with speckles of a brown and pink substance in it. The medication cart was observed unattended; approximately three to four minutes later, Registered Practical Nurse #044 was observed exiting a resident room, the door to the room had been closed. Residents were observed walking or wheeling past the medication cart, in the hallway.

- June 08, 2016 – the medication cart was observed sitting in the lounge area, near the nursing station on a specific resident home area, a bottle containing a laxative was observed sitting on top of the medication cart; the medication cart was unattended. Residents were observed in the lounge and walking or wheeling past the medication cart.

Registered Practical Nurse #044 acknowledged that the medication cups, observed on the medication cart on June 02, 2016, contained medications. Registered Practical Nurse #044 provided confirmation that medication was not to be left unattended.

The Acting Director of Care indicated it would be the expectation that all medications are stored in an area or a medication cart that is secure and locked. [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 ensuring there is a process in place and monitored to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by not ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Intake #015981-16:

The home's Bowel Care Protocol directs the following:
- Day 3 – if no bowel movement, give a specific laxative, one dose of either at 16:00 hours;
- Day 4 – if no bowel movement, administer one suppository rectally, one dose at 0600 hours;
- Day 5 – if no bowel movement, administer one enema rectally, one dose at 07:00 hours;
- If no results, notify physician.

The Acting Director of Care indicated that a written complaint was submitted by a registered nursing staff member on two separate dates, alleging that Registered Practical Nurse #034 was making false entries in resident's clinical health care record, specific to identified residents defecation patterns.

Registered Nurse (RN) #035 indicated in the written complaint to the Acting Director of Care, giving identified residents a laxative on identified dates, as residents had not had a bowel movement in three days; when RN #035 was following up on results of the laxative administered it was discovered that Registered Practical Nurse #034 had marked residents as having defecated, creating what appeared to be medication errors by RN #035.

During the home's investigation it was found that Registered Practical Nurse #034 had entered into Point of Care (electronic daily flow sheets records, which are part of the resident health care record) that residents #009, 010, 016, 017, as well as three other

residents had defecated, on specific dates, when the identified residents had not.

Defecation patterns, specific to resident's #009, 010, 016 and #017, were reviewed for April 2016; this review provided supporting documentation that the identified residents inconsistently had a bowel movement every three days and hence required bowel protocols to be implemented. The review provided further documentation to support that bowel protocols were not administered on day four or day 5, due to Registered Practical Nurse #034 falsely recording that the identified residents had defecated; it was further noted that residents identified did at times not have a bowel movement for five to eight days due to Registered Practical Nurse #034's inappropriate documentation and or actions.

Acting Director of Care and the Executive Director both indicated that Registered Practical Nurse #034 failed to administered medications as per the physician's orders, specific to bowel care protocols. The Acting Director of Care and the Executive Director indicated Registered Practical Nurse #034 placed residents at risk for potential harm due to his/her actions.

Registered Practical Nurse #034 has since received re-training and is his/her practice is being monitored. [s. 131. (2)]

Additional Required Actions:

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to medication management.

Under O. Reg. 79/10, s. 114 (1), every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The home's policy, Medication Administration (#LTC-F-20) directs that medications will be administered following the "rights" of medication administration; and that all medications administered, refused or omitted will be documented immediately after administration on the paper/electronic MAR using proper codes by the administering nurse.

The Acting Director of Care received a written concern by a registered nursing staff, on an identified date, alleging that Registered Practical Nurse #034 was not administering medications according to the home's policies and or College of Nurses Standards.

During the home's investigation of the allegation, it was found that on more than one occasion Registered Practical Nurse #034 was signing for identified resident's medications all at once and not individually following medication administration.

The Acting Director of Care and the Executive Director provided confirmation that Registered Practical Nurse #034 was not following the home's policy, specific to medication administration. [s. 8. (1) (b)]

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

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Issued on this 17th day of June, 2016

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

Original report signed by the inspector.