Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2017	2017_484646_0010	016314-17	Resident Quality Inspection

Licensee/Titulaire de permis

City of Toronto
55 JOHN STREET METRO HALL, 11th FLOOR TORONTO ON M5V 3C6

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

FUDGER HOUSE
439 SHERBOURNE STREET TORONTO ON M4X 1K6

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

IVY LAM (646), GORDANA KRSTEVSKA (600), NATALIE MOLIN (652), NITAL SHETH (500)

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): July 26, 27, 28, 31; August 1, 2, 3, 8, 7, 10, 11, 14, 15, 16, 17, 18, 21, 2017.

The following critical incident (CI) inspections were conducted concurrently with the RQI:

Related to duty to protect: 008346-15, 028851-15, 002317-17, 021228-16, 027256-16, 026720-16,

Related to transferring and positioning: 028851-15,
Related to prevention of abuse and neglect: 031665-16, 019074-17, 019075-17,
Related to reporting and complaints: 027256-16, 026720-16, 018975-16,
Related to falls prevention and management: 008547-17,
Related to administration of drugs: 018975-16, and
Related to plan of care: 018975-16.

The follow complaint inspections were conducted concurrently with the RQI:

Related to authorization for admission to a home: 010084-15,
Related to infection prevention and control program: 018257-15,
Related to pest control: 018257-15,
Related to residents' bill of rights: 020737-15, 030805-16,
Related to duty to protect: 020737-15, 024800-16,
Related to dining and snack service: 021734-15,
Related to falls prevention management: 021734-15,
Related to requirement on licensee before discharging a resident:021734-15,
Related to restorative care: 021734-15,
Related to nursing and personal support services: 021734-15,
Related to accommodation services: 021734-15,
Related to responsive behaviours: 024800-16,
Related to non-allowable resident charges: 030805-16
Related to foot care and nail care: 030805-16,
Related to continence care and bowel management: 030805-16, 010710-17,
Related to housekeeping: 030805-16,
Related to information and referral assistance: 030805-16,
Related to plan of care: 030805-16, 010710-17,
Related to prevention of abuse and neglect: 004682-17, and
Related to laundry service: 010710-17.

During the course of the inspection, the inspector(s) spoke with the administrator, acting assistant administrator, director of nursing (DON), medical director, food service workers, food service supervisor, registered dietitian (RD), nurse managers (NM), registered nursing staff, practical care aides (PCAs), manager of resident services, recreation service assistant, physiotherapist, occupational therapist, counsellors, residents, substitute decision makers (SDMs), Residents' council

president, Family council representative and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home and observed meal service, medication administration, staff to resident interactions and the provision of care, and reviewed health records, staff training records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A Critical Incident System (CIS) report was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, indicating resident #005 complained to an identified person that he/she had received an identified abuse by Personal Care Aide (PCA) #146 on an identified part of his body from the previous identified shift. The identified person then informed the home.

Interviews with PCA #149 and Registered Nurse (RN) #113, to whom the identified person reported the incident involving resident #005, and Nurse Manager (NM) #115 who conducted the home's investigation, revealed that the resident provided the same statement that he/she had given to the identified person the day after the incident.

Review of the home's assessment of resident #005 at the time did not reveal any visible injuries.

Interview with PCA #146 revealed that resident #005 required an identified level of eating assistance related to a specific medical diagnosis. PCA #146 further revealed that on the day of the alleged incident, a food service worker placed a plate of food in front of resident #005 during an identified meal without a staff present to assist the resident. PCA #146 had observed resident #005 about to take a bite of food from his/her identified eating utensil on his/her own, and had stated to the resident that he/she cannot eat on his/her own. PCA #146 further revealed that he/she had held resident #005's identified part of the body to remove the plate of food from him/her and further revealed that resident #005 looked upset. The PCA revealed that he/she did not apologize to resident #005 for taking away the food. PCA #146 further stated that if he/she were a resident, he/she would be upset if someone had taken his/her food away.

Interviews with PCA #146, #149, RN #113, and NM #115 revealed that resident #005 was a pleasant resident and was not known to refuse or resist staff care, or complain about staff members.

PCA #146 did not confirm that he/she had interacted with the resident in an identified way as per resident's allegations. Resident #005 was not available for interview.

Interviews with NM #115 and the Director of Nursing (DON) revealed that PCA #146's treatment of resident #005 was not acceptable and resident #005's right to be treated with courtesy and respect had not been fully promoted.

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 following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the designate of the resident / substitute decision maker (SDM) been provided the opportunity to participate fully in the development and implementation of the plan of care.

Ministry of Health and Long-Term Care (MOHLTC) received a complaint regarding the provision of Resident's Bill of Rights to resident #016.

Record review of the home's referral form to the occupational therapist (OT) on an identified date indicated that RN #162 had requested an assessment of resident #016's use for an identified assistive device, and if necessary, be removed to reduce an identified risk to the resident. This form also revealed a response by the OT that mentioned a discussion was held with the RN in charge with regards to the identified assistive device and the resident's abovementioned risk, and that it was agreed to remove the identified assistive device to reduce the identified risk, and will monitor for transfer and bed mobility. Work requisition done to remove the identified assistive device.

Record review of the progress notes on an identified date revealed resident #016 was upset with the removal of his/her identified assistive device.

Record review of the home's referral form to physiotherapy on an identified date, revealed the RN mentioned it was difficult to provide an identified care for resident #016 without the identified assistive device, and requested for the resident to be reassessed. On this same form a response by the physiotherapist (PT) mentioned for OT to follow-up.

Record review of the home's referral form to the OT on an identified date, revealed resident #016's family requested to reinstall the identified assistive device, and NM #119 had agreed to it. The OT's response on this form on a later identified date also revealed resident #016 has been assessed by an identified outreach team by an identified health professional, and there were no safety concerns at this time, and that it was safe to reinstall the identified assistive device, work requisition done.

Interview with resident #016's SDM revealed that the home did not inform him/her that resident #016's identified assistive device had been removed, and requested management to have resident #016's identified assistive device has been replaced.

Interview with the acting NM #119 revealed resident #016's assistive devices were removed in relations to the identified risk to the resident at the time. The NM further indicated that there had been no discussion with the resident's SDM at the time the identified assistive device had been removed. [s. 6. (5)]

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

An identified CIS report was submitted to the MOHLTC on an identified date indicating about resident #006's complaint of abuse from a staff member.

Observation of resident #006 and review of the resident's chart revealed that resident had an identified level of cognitive skills. The resident needed an identified level of assistance by an identified number of staff for all activities of daily living (ADLs) including bed mobility and continence care due to an identified medical condition.

Review of the resident's written plan of care revealed that the resident had been identified to require the identified level assistance by the identified number of staff for bed mobility and continence care including personal care at night when he/she was in bed.

Review of resident #006's progress notes revealed that on an identified date, he/she complained to the NM #115 regarding inappropriate actions by PCA #145 during the personal care that morning.

Interview with PCA #143 revealed on an earlier identified date, he/she worked an identified shift with PCA #145 and PCA #145 provided care to resident #006 alone. PCA #143 confirmed that he/she knew resident #006 required the identified level of assistance by the identified number of staff for bed mobility and continence care and he/she did offer to assist to PCA #145, but the PCA refused saying that he/she will be good on his/her own.

Interview with NM #115 confirmed that the staff is expected to follow the resident's written plan of care. He/she also confirmed at this time this particular PCA did not comply with the resident plan of care as he/she provided the identified continence and repositioning assistance for the resident on his/her own despite the guidelines from the plan of care. [s. 6. (7)]

3. A complaint was submitted to the MOHLTC by SDM of resident #017 on an identified date, regarding concerns for continence care and bowel management. Interview with the complainant revealed that the resident had an identified medical condition and he/she had requested an identified medication from the physician. The complainant further stated that staff had not been giving the identified medication to the resident regularly.

Review of the resident's MDS records for the last three quarters for continence assessment, revealed resident #017 was identified to be at risk of having the identified medical condition recur.

Review of the resident's plan of care revealed that the resident had been identified to be at risk for the identified medical condition and was ordered an identified protocol. Review of the home's policy titled, "Continence Management -- #RC-02520-00," published on an identified date, revealed that the identified protocol gave direction to the staff to follow Decision Algorithm for management of residents at risk of the identified medical condition, which identified the stepwise treatment given to the resident based on the symptoms shown by the resident each day.

Review of the Nursing and Personal Care Record for an identified period of time indicated that the resident had shown the identified symptoms on an identified number of days.

Review of the medication administration record (MAR) for an identified month revealed the resident was ordered two identified medications to be administered at a specified interval as needed. Review of the MAR revealed this had only been given once in the month. Review of MAR for another identified month failed to reveal that the identified protocol was followed on the identified dates when the resident showed the identified symptoms.

Interview with RN #102 indicated that the staff were aware that if the resident had shown the identified symptoms, the identified protocol should be implemented as ordered, but the RN was not able to confirm if the resident received the identified treatment for the abovementioned dates as per the identified protocol.

Interview with the DON confirmed the staff was expected to follow the identified protocol. [s. 6. (7)]

4. The home submitted an identified CIS report to the MOH on an identified date, related to resident #010's allegations of an inappropriate behaviour by co-resident #023. Resident #010 was not able to provide a specific date or time for when the incident occurred.

Review of resident #023's written plan of care on an identified date, revealed that resident #023's exhibited behaviours included an identified inappropriate behaviour with co-resident. The co-resident was identified to be resident #010.

Interventions per resident #023's written plan of care included an identified level of

monitoring for resident #023 starting on an identified date.

Review of resident #023's progress notes revealed that on identified number of days between an identified period of time, resident #023 was not provided with the identified monitoring as per his/her written plan of care. Further review of the progress notes revealed that on two identified dates, resident #010 had attempted to enter resident #023's room, and was redirected by a PCA.

Interview with NM #119 revealed that resident #023 was to continue on the identified monitoring strategy as per the resident's written plan of care, but there are times when the resident was not provided the identified monitoring when the home is not able to find staff who were available to work. NM #119 further revealed that the resident was not provided the care as specified in the resident's written plan of care.

Interview with the DON revealed that resident #023 was not provided the specified care on the abovementioned dates as per the resident's written plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
1. The resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care,

2. The care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

An identified CIS report, submitted by the home to the MOHLTC on an identified date, resident #011 had an identified incident. The resident was sent to a hospital with an identified injury and returned to the home on an identified date.

Review of resident #011's chart revealed the resident's admitting diagnoses. The chart further revealed that the resident had one routine and another identified medication prior to the incident on the identified date.

Review of resident #011's written plan of care revealed that the resident was identified to have alterations in comfort, and one of the interventions for the goal to minimize the discomfort and for RN/RPN to assess and document the discomfort using an identified assessment tool.

Review of the resident progress notes on an identified period of time revealed the resident had an identified number of incident from which he/she had sustained injuries.

Review of the resident chart and progress notes failed to reveal that the resident had been assessed using a clinically appropriate assessment instrument specifically designed for the identified alteration.

Review of home's policy revealed that the home shall have a process for assessment and management of the identified alteration in comfort for all residents. Further the policy review revealed the RN/RPN should complete the identified assessment tool for all

residents when there is significant change in health status and when a request for medication for the identified comfort level is administered for 48 hours consecutively.

Interview with RN #113 revealed that the staff were aware of resident #011's alterations in comfort and have observed the resident for signs for discomfort, however he/she confirmed that they have not assessed the resident using the clinically appropriate assessment instrument specifically designed for assessment of the identified discomfort.

Interview with the NM #115 confirmed that the RN/RPN are expected to assess the resident for the identified discomfort on admission, every quarter, and when resident condition change, using the identified assessment tool. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: 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 the residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

An identified CIS report was submitted to the MOHLTC on an identified date for alleged abuse.

Review of the CIS report revealed that on an identified date, RN #130 had administered an identified medication to the wrong resident despite the statement from resident #012 that he/she is not to receive the identified medication.

Review of resident #012's progress notes revealed that on an identified date at an identified time, PCA #131 reported to RPN #128 that RN #130 had administered an identified medication to resident #012. The RPN assessed and interviewed the resident #012, who confirmed that he/she told the RN that he/she does not receive the identified medication. However the RN had administered it to him/her. Further review revealed that the RN had denied the allegation.

Interview with resident #012 confirmed that he/she received the identified medication on an identified date, although he/she had told the RN that he/she should not receive it.

Interview with PCA #131 revealed that on the identified date, he/she was providing care to resident #012's roommate when he/she heard RN #130 telling resident #012 that he/she had prepared and was to administer an identified medication. Resident #012 asked the RN why he/she had to take the medication as this was not what he/she normally receives. The PCA overheard the RN stating that the resident needed that medication and had to have it. The PCA approached the RN and told him/her the full name of resident #012 to ensure the RN had the right person, and the RN replied that he/she knew who the resident was. PCA #131 reported his/her concern to RPN #128.

Interview with RPN #128 revealed that PCA #131 approached him/her on the same day, expressing concern regarding RN #130 providing the identified medication to resident #012 who did not require it. Further the RPN revealed that he/she assessed the resident, who confirmed that he/she received the identified medication and interviewed the RN. The RN denied that he/she had provided the identified medication to resident #012.

Review of the home investigation notes revealed RN #130 initially denied that he/she had provided the medication to resident #012, and later after he/she admitted that he/she actually did provide the medication, but denied that the resident had told him/her was that he/she was not to receive the medication.

Interview with RN #130 confirmed that on the identified day, he/she entered the room of resident #012 and provide the identified medication to the resident. The RN also confirmed that he/she did not check the MAR to confirm resident's name and did not

confirm the resident's identity. The RN further stated that resident #012's first name started with the same letter as the resident who was to receive the identified medication at that time so he/she became little bit confused.

Interview with PSW #131 confirmed that the RN #130 did not take any action when the resident expressed concerns of having the identified medication and did not take any action when the resident's roommate had stated that resident #012 was not to have the identified medication, or when PSW #131 told the resident's name, the RN did not check the resident's medication order and record to clarify the concerns of the residents and the PSW.

Interview with the DON confirmed that all staff is expected to verify the resident's identity before they administer medication or treatment. The DON also confirmed RN #130 failed to address the residents' concern when they indicated the resident #012 was not to receive the identified medication. [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 the residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with.

The home submitted an identified CIS report to the MOH regarding an incident on an identified date, when PCA #123 observed an identified interaction between PCA #141 and resident #007. PCA #123 did not report this to the home until several days later.

Review of the home's policy directed staff to inform the RN/RPN immediately on becoming aware of any and every alleged, suspected or witnessed incidents of abuse or neglect, in order for the home to commence an immediate investigation and reporting.

Interview with PCA #123 who witnessed the incident revealed that on the day of the incident, while entering resident #007's room to provide an identified care, he/she had witnessed PCA #141 initiate an identified interaction with resident #007 when the resident refused PCA #141's instructions. PCA #123 further revealed that PCA #141 was not aware of his/her presence in the room. PCA #123 indicated that he/she left the room and neither confronted PCA #141, nor reported the incident to the management, as he/she was shocked by the incident, and also did not want to get PCA #141 in trouble.

PCA #123 revealed that he/she later came forward to report the incident to NM #135 because he/she felt what PCA #141 did was wrong and it was abuse of resident #007.

Review of the home's Team Assignment on an identified period after the incident revealed that PCA #141 continued working with resident #007, and had an identified number of shifts where he/she continued to provide care for resident #007 after the alleged incident. NM #135 further confirmed that PCA #141 had worked with resident #007 after the incident, before the NM was informed of the incident.

Interview with resident #007 revealed that he/she could not recall the PCA #141 or the incident.

Interview with PCA #141 revealed that he/she did not confirm the allegations of the incident.

Interview with NM #135 revealed that PCA #123 did not report the alleged abuse immediately to the managers or the registered staff or nurse-on-call, as per the home's expectation and abuse policy. NM #135 further revealed that PCA #141 was removed from resident #007's assignment after the incident was informed to NM #135. [s. 20. (1)]

2. The home submitted an identified report to the MOHLTC regarding an alleged inappropriate behaviour by resident #018's SDM to resident #010 that occurred on an identified date. Resident #010 reported the incident to the home about one week after the incident. However, further investigation from the home revealed that resident #018's SDM had reported the allegations of resident #010 regarding him/her to Recreation Services Assistant (RSA) #154 three days after the incident.

Review of the home's policy directed staff to inform the RN/RPN immediately on becoming aware of any and every alleged, suspected or witnessed incidents of abuse or neglect, in order for the home to commence an immediate investigation and reporting.

Interview with RSA #154 revealed that on the day resident #018's SDM reported the incident to him/her, the resident's SDM had told him/her of resident #010's allegations, and that this was not true. RSA #154 further revealed that he/she had assumed the SDM had told the managers in the home, and had not reported the allegations of inappropriate to the management of the home.

Interview with the current DON revealed that the home's management was not made aware of the incident until about a week after the alleged incident. The DON further revealed that the reported incident was reported as an identified alleged abuse, and the staff member should have reported the incident right away to the management in the home, as per the home's Zero Tolerance of Abuse and Neglect policy. [s. 20. (1)]

3. The home submitted an identified CIS related to an alleged visitor to resident inappropriate behaviour reported by the SDM of resident #024, who had observed the inappropriate behaviour between the SDM of resident #018 and resident #009. The SDM of resident #024 reported the incident on an identified date to RN #160, and again to Counsellor #155 and NM #158 two days later. This incident was not reported to the Director until six days after the initial identified date.

Review of the progress notes revealed that no entry was written regarding the alleged incident until about 1 week after it was initially reported to RN #160, when RN #160 recorded a late entry regarding the report he/she received from the SDM of resident #024 of the alleged incident.

Review of the home's policy directed the RN/RPN to inform the Nurse Manager/RN-in-Charge immediately once an allegation, suspicion or witnessed of abuse and/or neglect

has been made , and to inform the Director of Nursing/Care, Administrator and GM immediately of the allegation, suspicion or witnessed incident of abuse and neglect. The same policy reveals that all managers were to notify the MOHLTC immediately that an alleged, suspected or witnessed incident of abuse or neglect has become known and an investigation is underway.

Interview with NM #158 revealed that RN #160 did not tell any staff regarding the alleged incident reported to him/her on the initial identified date. NM #158 further revealed that resident #024's SDM reported the incident to Counsellor #155 and NM #158 two days after he/she first reported to RN #160.

Interview with Counsellor #155 revealed that resident #009 could not recall the incident.

RN #160 was not available for interview and was not working in the home at the time of the inspection.

Interview with NM #158 revealed that the staff had wanted to verify the information and conduct further interviews and did not report this incident to the DON and the Director until several days after the incident was reported to him/her. NM #158 further revealed that they should have reported the alleged abuse immediately to the MOHLTC.

Interview with the current DON revealed that the reported incident was reported as an identified alleged abuse, and RN #160 and NM #158 should have followed the home's policy to report the alleged incident to the appropriate designated management staff. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #6: 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 has failed to ensure that the 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: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

The home submitted an identified CIS report to the MOHLTC on an identified date, for reporting an incident that happened on an identified date 23 days prior to when it was reported to the Director.

Review of the CIS report revealed that on the identified date, RN #012 had given an identified medication to a wrong resident despite the statement from the resident that he/she was not to receive the identified medication. The CIS report was completed and submitted by RN #119, 23 days after the identified date of the incident.

Review of resident #012's chart revealed that on the identified date and time of the incident, PCA #131 reported to RPN #128 that RN #130 had given the identified medication to resident #012. The RPN assessed the resident immediately and

interviewed him/her. The resident confirmed that he/she told the RN that he/she was not to receive the identified medication, however, the RN had given to her. The RPN reported the incident to the RN on another floor who notified the manager on duty, the DOC at that time. The investigation started immediately.

Interview with RN #119 revealed that the incident happened on an identified shift on the identified date. The PSW staff notified the RN on duty who contacted the manager on duty who happened to be the DON. On an identified time on an identified number of days later, when the nurses were giving report to RN #119, at the same time the DON called the RN to tell him/her to report the incident.

RN #119 further stated he/she was worried for the resident's safety so to prevent that kind of incident from happening again to another resident, he/she started the investigation instead.

RN#119 confirmed he/she did not report the incident to the Director until he/she completed the investigation, which was 23 days after the incident.

The identified DON was no longer employee at the home. Interview with a present DON confirmed that the staff was educated and should be aware to report to the Director any witnessed or suspected abuse or neglect. [s. 24. (1)]

2. This inspection was initiated in response to an identified CIS Report submitted by the home related to an alleged visitor to resident inappropriate behaviour, where on an identified date, resident #010 reported to the Counsellor #156 and NM #119.

Review of the resident's progress notes revealed that he/she had reported the incident to NM #119 and counsellor #156 on the identified date.

Interview with NM #119 revealed that on the identified date, resident #010 had informed the NM and Counsellor #156 that resident #028's SDM had acted inappropriately toward resident #010, but the resident was not able to clearly identify the date when this incident had occurred.

NM #119 further revealed that this incident was not informed to the Director until several days after the date that the resident reported the incident, as he/she wanted to clarify the information from resident #010.

Interview with NM #119 and the DON revealed that this incident was considered to be allegations of abuse, and should have been reported to the Director immediately. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
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:
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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

This inspection was initiated for resident #003 during the Resident Quality Inspection (RQI).

Review of resident #003's current written plan of care, dietary list, and physician medication review, revealed that the resident received an identified diet of an identified modified texture, and also received an identified nutrition supplement at a specified

mealtime.

Review of resident's Nursing and Personal Care Record (NPCR) for food and fluid intake on two identified months revealed that there was no documentation for supplement intake at meals or with snacks.

Review of the home's policy "Nursing and Personal Care Record - Food and Fluid Intake -- Section 02 - Organization & Administration" NU-0211-04, published 01-07-2013 directed registered staff to document residents' meal, fluid and supplement intake if taken at mealtime, on the NPCR for food and & fluid intake immediately after each meal service. The abovementioned policy also directed the PCAs to document snack, food, fluid and supplement intake on the NPCR for food and fluid intake immediately after resident's intake.

Interview with RPN # 109, nutrition manager #110 and RD #108 identified that resident #003 routinely continues to accept the identified nutritional supplement at the specified meal.

RD #108 further revealed that it is the home's expectation for registered staff to document the identified nutritional supplement on the NPCR food and fluid intake form, and that the staff should specify the name of the nutritional supplement and the meal that it should be provided on, on the NPRC intake form and document that the supplement was taken.

Interview with RPN #109 further revealed that he/she it was not aware that it should be the registered staff who should document supplement intake at mealtimes.

Nutrition manager #110 revealed that she has not reviewed resident #003's NPCR -- Food and Fluid Intake documentation, but would find out about resident's intake based on conversation with the staff and on his/her observations of the resident.

Interviews with PCA #111 and RPN #104 revealed that documentation of supplements at mealtimes should be completed by registered staff.

Interview with RD #108 revealed that it is the home's expectation to have staff document residents' intake of nutritional supplements on the NPCR food and fluid intake form and this is a gap in the documentation of interventions provided to residents that the home management planned to address. [s. 30. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when placement co-ordinator gave the licensee of selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee reviewed the assessments and information, the applicant's admission to the home was approved.

A complaint was submitted to the MOHLTC regarding withholding approval for admission of applicant #013 due to the applicant's identified behaviour.

Review of the withholding approval of admission letter for applicant #013, sent by the home on an identified date revealed that the application was withheld for admission approval due to the applicant's behaviours and because the home did not have the resources to provide the nursing expertise necessary to meet the care requirement of this applicant.

Interview with RN #101 revealed that the home has well established responsive behaviour program in the home working successfully for four years using as a support outside resources like Geriatric –Mental Health outreach team (GMHOT), the Baycrest Behaviour Support of Ontario (BBSO), Behave Support Specialist (BSS), Psychogeriatric Resources Consultant (PRC), and Pain consultant. The program had a lead and staff who were well trained to manage the program. The program was evaluated and revised on annual basis.

Interview with Manager of Resident Services confirmed that the home had established responsive behaviour program and he/she was not sure why the withhold approval for admission letter stated that the home did not have the environment and the resources to provide the nursing expertise necessary to meet the care requirement of this applicant. The Manager of Resident Services further confirmed that the home did withhold the approval for admission of this applicant and also stated their capacity for admission of applicant experiencing responsive behaviour was full. [s. 44. (7) (b)]

Issued on this 28th day of September, 2017

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

Original report signed by the inspector.