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
Dec 29, 2016	2016_264609_0024	026781-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the City of Timmins
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD TIMMINS ON P4N 5H3

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

CHAD CAMPS (609), MISHA BALCIUNAS (637), RYAN GOODMURPHY (638), SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 6-9 and 12-16, 2016.

Additional logs inspected during this RQI included:

Three Critical Incidents the home submitted to the Director related to allegations of resident to resident abuse;
Four Critical Incidents the home submitted to the Director related to allegations of staff to resident abuse; and
One Critical Incident the home submitted to the Director related to allegations of improper care of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Nursing Care Coordinator (NCC), Resident Assessment Instrument (RAI) Coordinator, Pharmacist, Manager of Dietary, Housekeeping and Laundry Services, Maintenance Manager, Resident Services Supervisor (RSS), Activity Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food Services Workers (FSWs), residents and family members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed numerous licensee policies, procedures, programs, internal investigations, relevant human resource files, relevant health care records, training logs and council meeting minutes.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
12 WN(s)
6 VPC(s)
2 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. (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).

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

Findings/Faits saillants :

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

Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director in June 2016 which alleged staff to resident verbal abuse, when PSW #110 yelled across the hallway at resident #040 while they attempted to toilet themselves during the night on a particular day.

The Inspector reviewed resident #040’s care plan which found the interventions identified that the resident was to use a specific mode to toilet. This intervention had been changed previously from the mode employed on the particular night cited.

The Inspector reviewed resident #040's health care records which found that on another particular night, the resident had been toileted twice using the outdated mode to toilet.

During an interview with the DON they verified that the staff were using two different methods for toileting the resident during the night, yet the care plan instructed that the resident was to only use one mode of toileting at night. [s. 6. (7)]

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

Inspector #609 reviewed the most current Minimum Data Set (MDS) assessment for

resident #001, which indicated that the resident’s urinary continence had deteriorated since the previous MDS assessment.

A review of the plan of care for resident #001, indicated that staff were to use a specific product to manage the resident’s urinary incontinence.

During an interview with resident #001, they stated they used a different product than the one specified in their plan of care related to increased urinary incontinence.

During an interview with PSW #106, they verified that resident #001’s urinary incontinence had deteriorated and that the product used to manage their incontinence had changed. PSW #106 also verified that when a resident’s care needs changed that the plan of care was to have been reviewed and revised. [s. 6. (10) (b)]

3. Inspector #603 reviewed a CI report submitted to the Director in August 2016. The CI alleged resident to resident sexual abuse when on a particular day, PSW #150 observed resident #025 with both hands on resident #026 in sexual manner.

An interview with PSW #114 found that resident #025 had a history of seeking out certain residents. Before the incident with resident #026, the staff utilized three specific interventions to reduce resident #025's inappropriate sexual behaviours.

Inspector #603 interviewed resident #025's family and verified that the resident had a history of inappropriate sexual behaviours.

A review of resident #025's care plan at the time of the incident with resident #026 found no mention of the identified inappropriate sexual behaviours and although, the incident of inappropriate sexual behaviours occurred on a particular day, it wasn't until multiple days later that resident #025's care plan was updated to include a focus and interventions for inappropriate sexual behaviours.

During an interview with the DON they verified that resident #025 was known to have inappropriate sexual behaviours towards other residents before the incident with resident #026 and that resident #025's plan of care was not revised until days after the incident. [s. 6. (10) (b)]

4. Inspector #638 reviewed a CI report submitted to the Director which indicated that resident #020 had struck resident #023 on a particular day.

A review of the progress notes for resident #020 indicated that resident #023 had stated that resident #020 had struck them on a particular day. Further review of the progress notes for resident #020 also indicated that on another particular day, it was alleged that resident #020 had struck resident #019.

Inspector #638 reviewed the internal investigation notes that indicated resident #020 had a history of altercations, typically instigated by an identified trigger.

A review of the plan of care for resident #020 found no mention of the identified trigger for responsive behaviours.

During an interview with Inspector #638, the DON and NCC indicated that the potential or actual triggers for responsive behaviours should have been reviewed and the plan of care revised to have included them. The DON and NCC further indicated that the identified trigger for resident #020's physically responsive behaviours was not revised in their plan of care. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: 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 was complied with.

A CI report was submitted to the Director in July 2016 which outlined allegations that PSW #112 verbally abused resident #021.

Inspector #609 reviewed the home's internal investigation which substantiated the allegations that when resident #021 asked for assistance, PSW #112 did not provide assistance and made demeaning comments to the resident. PSW #112 acknowledged that their actions and comments were unprofessional and inappropriate.

During an interview with resident #021, they described how on a particular day, they were in significant arm and back pain and asked for assistance from PSW #112 who denied them help and made demeaning comments to them.

The Act defined verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect- COT-GMA-G10-v08" last revised June 15, 2016, indicated that all residents of the home were to be free from all forms of abuse, including verbal abuse.

During an interview with the DON on September 14, 2016, they verified that PSW #112's actions toward resident #021 a particular day, constituted verbal abuse. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, that the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

On a particular day, Inspector #609 observed two upper quarter bed rails engaged in the guard position on the bed of resident #001.

A review of the bed entrapment risk assessment for resident #001's bed found that there was no way to determine which bed or which mattress had passed the bed entrapment risk assessment as there were no corresponding labels to track which bed or mattress went with the assessment.

During an interview with the NCC and the RAI-Coordinator, they both stated that bed rail use in the home was directed by the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings" document dated April 2003.

A review of the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings" was completed. The document indicated that maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items should be ongoing.

During an interview with the NCC and the RAI-Coordinator, they both verified that there was no way to monitor the bed systems as the home currently did not have a method to track which bed, mattress or accessories were assessed. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, that the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of maintenance services for the home.

Observations made by Inspector #638 with the Maintenance Manager found that:

The first floor tub room located in the east wing, had a substantial amount of rust discolouration to the floor coming from behind the tub appliances;
The second floor tub room located in the east wing, had extensive unfinished patches and damaged drywall on each wall and damaged and chipped floor tiles throughout;
The third floor tub room located in the east wing, had extensive unfinished patch jobs to each wall and large sections of damaged and chipped tile on the flooring;
The sink located in room #301-1 was corroded and the caulking was peeling away;
The sink drain located in room #310-1 was corroded with rust and a stained facecloth was tied around the base of the drain; and
The sink drain located in room #126-1 was extensively corroded and stained.

In an interview with Inspector #638, the Maintenance Manager stated that the building was to remain in a good state of repair and that there was currently no written organized program of maintenance in the home. The Maintenance Manager also stated that there was no formal auditing tool utilized by maintenance staff in order to ensure that the home remained in a good state or repair.

During an interview with Inspector #638, the DON verified that there was currently no organized program of maintenance services within the home. [s. 15. (1) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours.

Inspector #603 reviewed a CI report submitted to the Director in August 2016, which alleged resident to resident sexual abuse when on a particular day, PSW #150 observed resident #025, with both hands on resident #026 in sexual manner.

An interview with PSW #114 found that resident #025 had a history of seeking out certain residents. Before the incident with resident #026, the staff utilized three specific interventions to reduce resident #025's inappropriate sexual behaviours.

Inspector #603 interviewed resident #025's family and verified that the resident had a history of inappropriate sexual behaviours.

A review of resident #025's care plan at the time of the incident with resident #026, found no mention that certain residents were triggers for inappropriate sexual behaviours.

During an interview with the DON they verified that resident #025 had sought out certain residents and displayed identified inappropriate sexual behaviours in the past, the care plan did not include sexual behavioural triggers that had been previously identified. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that behavioural triggers are identified for resident #025 and all other residents who demonstrate responsive behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee’s written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who had been abused or neglected or allegedly abused or neglected.

A CI report was submitted to the Director in July 2016 which outlined allegations that PSW #112 verbally abused resident #021.

Inspector #609 reviewed the home’s internal investigation which indicated that PSW #112 did speak inappropriately to resident #021 on a particular day.

A review of the home’s policy titled “Zero Tolerance of Abuse and Neglect- COT-GMA-G10-v08” last revised June 15, 2016, found no mention of procedures and interventions to assist and support residents who had been abused or allegedly abused.

During an interview with the Resident Services Supervisor (RSS), a review of the home’s zero tolerance of abuse and neglect policy was conducted. The RSS verified that the policy did not contain procedures and interventions to support residents who had been abused or allegedly abused. [s. 96. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift recorded symptoms of infection in residents and had taken immediate action as required.

Inspector #638 reviewed the MDS assessment dated in July 2016 for resident #005 which indicated that the resident had a deterioration in their health condition from the previous MDS assessment.

A review of resident #005's health care records found that the resident had demonstrated signs and symptoms of infection which commenced on a particular day. In the physician communication binder no notation had been made regarding the signs and symptoms exhibited by resident #005. A review of the physician orders for resident #005 indicated that an order for medication was created on a particular day, in order to treat the infection.

At the time of inspection, the home was unable to provide any Infection Control Surveillance document records for resident #005 to verify monitoring of the resident's symptoms during their infection.

A review of the home's policy titled “Signs and Symptoms of Infection in the Elderly– IFC B-15” last reviewed December 30, 2015, indicated that when signs and symptoms had been noted, the signs should be reported to registered staff, documented in the resident’s chart and the Infection Control Surveillance document.

During an interview with Inspector #638, the DON and NCC indicated that resident #005 had demonstrated signs and symptoms of infection starting on a particular day. The DON and NCC both stated that a daily surveillance sheet should have been initiated and completed each shift while symptoms were present and that they were unable to provide any documentation of its completion at the time of inspection. [s. 229. (5) (b)]

2. Inspector #638 reviewed the Minimum Data Set (MDS) for resident #010, which

indicated that the resident's health condition deteriorated from the previous MDS assessment.

A review of the health care records for resident #010 found that on a particular day, the resident had a change in health status which prompted the initiation of the Infection Control Surveillance document.

The Inspector reviewed the Infection Control Surveillance document pertaining to resident #010, which found that 41 per cent of the time, the staff had not recorded the symptoms of infection the resident exhibited.

Inspector #638 interviewed RPN #100 who indicated that the Infection Control Surveillance document was implemented anytime a resident had demonstrated symptoms of an infection and was expected to be completed in its' entirety.

Inspector #638 interviewed the DON and NCC who both stated that the Infection Control Surveillance document was to have been completed each shift, while a resident displayed symptoms of an infection and verified that the Infection Control Surveillance document had not been fully completed for resident #010. [s. 229. (5) (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 staff on every shift recorded symptoms of infection in residents and take immediate action as required., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not supervised by staff.

Inspector #638 and #609 observed on September 6, 2016, that the east wing first floor tub room was unlocked at 1403 hours with cleaning chemicals left out in the room.

In an interview with Inspector #638, PSW #103 stated that it was the home's expectation that all tub rooms were closed and locked when not in use.

Further observations made by Inspector #638 and #609 on September 6, 2016, at 1430, found that both the west wing first floor tub room door and first floor servery door had been left open and unattended by staff.

During an interview with Inspector #638, RPN #101 stated that all non-residential areas were to be closed and locked when not in use or being supervised by staff and that both the servery and tub room should have been locked.

During an interview with Inspector #638, the DON stated that without exception all doors leading to non-residential areas were to have been kept closed and locked while not in use. [s. 9. (1) 2.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items, including personal aids labelled within 48 hours of admission and of acquiring, in the case of new items.

Observations made by Inspector #638 and #609 on September 6, 2016, found in the first floor of the west wing tub room used nail clippers and used bar of soap out on the counter top; with no means of identifying to whom they belong.

In an interview with Inspector #638, RPN #100 stated that all resident personal items were to be labelled and without identification staff wouldn't be able to determine who owned the items.

On September 15, 2016, Inspector #638 and the DON conducted a tour of the first floor, west wing tub room and observed a used comb without identification.

In an interview with Inspector #638, the DON stated that all personal belongings were to have been labelled for means of identification. [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that included an evaluation of the potential to restore function with specific interventions.

Inspector #609 reviewed the most current MDS assessment for resident #001, which indicated that the resident’s urinary incontinence had worsened from the previous quarterly assessment.

A review of resident #001’s last bladder and bowel assessment, found that the assessment did not address the potential to restore function with specific interventions.

During an interview with the DON, they verified that the bladder and bowel assessment currently used in the home did not address the potential to restore function with specific interventions for resident’s who were incontinent. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included communication of the seven-day menu to residents.

On September 6, 2016 Inspector #637 observed that during the evening meal service on the special care unit no seven-day menu was posted for the residents.

On September 6, 2016 both FSW # 117 and RN #118 verified that no seven-day menu was posted for the residents on the special care unit.

On September 7, 2016 Inspector #637 interviewed the Manager of Dietary, Housekeeping and Laundry, who verified that they were aware that no seven-day menu was currently posted in the special care unit. [s. 73. (1) 1.]

WN #12: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CI report was submitted to the Director in July 2016 which outlined an incident whereby RN #111 allowed the incorrect dosage of a medication to be administered to resident #030 on a particular day.

A review of the physician orders for resident #030 indicated that a specific amount of a medication was to be administered daily to resident #030.

During an interview with RN #111 they verified that on a particular day they forgot to correct a malfunction of equipment which resulted in incorrect dosage of a medication being administered to resident #030.

A review of the home's policy titled "Prescribing Privileges- 03-01-10" last revised on June 23, 2014, indicated that no drug was to be administered by the staff to a resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident.

During an interview with the DON, they indicated that drugs were to have been administered to residents in accordance with the directions for use specified by the prescriber and that this did not occur on a particular day, when resident #030 was not administered the correct dosage medication as prescribed. [s. 131. (2)]

Issued on this 30th day of December, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609), MISHA BALCIUNAS (637), RYAN GOODMURPHY (638), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_264609_0024
Log No. / Registre no:	026781-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 29, 2016
Licensee / Titulaire de permis :	The Corporation of the City of Timmins 481 Melrose Blvd., TIMMINS, ON, P4N-5H3
LTC Home / Foyer de SLD :	GOLDEN MANOR 481 MELROSE BOULEVARD, TIMMINS, ON, P4N-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Halt

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To The Corporation of the City of Timmins, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee shall:

a) Ensure that the care set out in the plans of care for all residents including resident #040, are provided to the residents as specified in the plans.

Grounds / Motifs :

1. 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.

Inspector #603 reviewed a Critical Incident (CI) report submitted to the Director in June 2016 which alleged staff to resident verbal abuse, when PSW #110 yelled across the hallway at resident #040 while they attempted to toilet themselves during the night on a particular day.

The Inspector reviewed resident #040's care plan which found the interventions identified that the resident was to use a specific mode to toilet. This intervention had been changed previously from the mode employed on the particular night cited.

The Inspector reviewed resident #040's health care records which found that on another particular night, the resident had been toileted twice using the outdated mode to toilet.

During an interview with the DON they verified that the staff were using two different methods for toileting the resident during the night, yet the care plan instructed that the resident was to only use one mode of toileting at night.

The scope of this issue was determined to have been isolated to care provided to resident #040 not as specified in their plan. There was a previous CO issued related to this provision during inspection #2015_273580_0006 on December 31, 2015. The severity was determined to have potential for actual harm to the health, safety and well-being of resident #040 as well as other residents in the home not provided care as specified in their plans. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee shall:

a) Ensure that all staff and specifically PSW #112 comply with the home's written policy to promote zero tolerance of abuse and neglect of residents.

b) Ensure that all residents and specifically resident #021 is not abused by anyone.

Grounds / Motifs :

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

A CI report was submitted to the Director in July 2016 which outlined allegations that PSW #112 verbally abused resident #021.

Inspector #609 reviewed the home's internal investigation which substantiated the allegations that when resident #021 asked for assistance, PSW #112 did not provide assistance and made demeaning comments to the resident. PSW #112 acknowledged that their actions and comments were unprofessional and inappropriate.

During an interview with resident #021, they described how on a particular day, they were in significant arm and back pain and asked for assistance from PSW #112 who denied them help and made demeaning comments to them.

The Act defined verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminished a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect- COT-GMA-G10-v08" last revised June 15, 2016, indicated that all residents of the home were to be free from all forms of abuse, including verbal abuse.

During an interview with the DON on September 14, 2016, they verified that PSW #112's actions toward resident #021 a particular day, constituted verbal abuse.

The scope of this issue was determined to have been isolated to the verbal abused suffered by resident #021 from PSW #112. There was two previous VPCs related to this provision issued to the home during inspection #2016_320612_0014 and #2016_273580_0006 on May 27, 2016, and December 31, 2015. The severity was determined to have been actual harm occurred to the health, safety and well-being of resident #021 when PSW #112 did not comply with the home's abuse policy. (609)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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