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 7, 2017	2017_600568_0007	007359-17	Resident Quality Inspection

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH P.O. BOX 3277 CAMBRIDGE ON N3H 4T3

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

DOROTHY GINTHER (568), JENNA BAYSAROWICH (667), NUZHAT UDDIN (532), SHERRI GROULX (519)

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): April 11, 12, 13, 18, 19, 20, 21, 24, 25, 2017.

Critical Incident # 1033-000024-16 log # 031113-16, Critical Incident # 1033-000026-16 log # 032471-16, Critical Incident # 1033-000019-15 log # 033425-15, and Critical Incident # 1033-000007-16 log # 006554-16 related to responsive behaviours; Critical Incident # 1033-0000250-165 log # 023354-16 and Critical Incident # 1033-000018-16 log # 030688-16 related to falls; and Complaint L-48954-LO log # 001729-17 related to improper care were conducted in conjunction with the inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Director of RAI and Quality Outcomes, Director of Food and Environment, Director of Programs, Social Worker, two Pharmacy representatives, eight Registered Practical Nurses, twelve Personal Support Workers, one maintenance staff, one Recreation Aide, a Residents' Council and Family Council representative, residents and their families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **7 WN(s)**
- **4 VPC(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protect from abuse by anyone.

Critical Incident (CI) #1033-000024-16 described an incident where a Personal Support Worker witnessed an identified resident exhibited responsive behaviours towards another resident. The other resident could not cognitively or physically stop the identified resident.

CI #1033-000026-16 described an incident where staff observed the identified resident exhibit responsive behaviours towards another resident. The co-resident was observed trying to to stop them but they were not capable. When the identified resident was asked what they were doing they turned red and laughed.

During a review of the progress notes for the identified resident over a six month period there were ten incidents of responsive behaviours directed towards co-residents.

During a review of the identified resident's plan of care it was noted that the resident demonstrated responsive behaviours and specific interventions were documented.

A Personal Support Worker told inspectors that that there had been occasions when the resident's responsive behaviours had escalated. The PSW recalled an incident where they had observed the identified resident exhibit responsive behaviours that had put another resident at risk of harm. That resident was not capable of protecting themselves due to a cognitive impairment. When asked what interventions had been put in place to protect other residents from harm, the PSW said that for the first while after this incident staff were providing a specific intervention, however it was discontinued not long after. At present, they have been told to monitor the identified resident when they are around others that would not be able to protect themselves.

A Registered Practical Nurse (RPN) / BSO lead told the inspector that BSO had followed the identified resident with respect to their responsive behaviours a number of months ago. The RPN said there had been specific interventions put in place following one or two incidents but some of these were discontinued when the resident had a temporary change in status. When asked what interventions remained in place to protect other residents now that the identified resident was feeling better, the RPN said that they were always monitoring the resident and if they saw the responsive behaviours they would intervene.

During an interview with Executive Director (ED) and the Director of RAI and Quality Outcomes (DRQO) they said BSO had completed an assessment but they acknowledged that no interventions were put in place to mitigate risk to other residents at that time. The ED and DRQO were shown documentation that detailed incidents of responsive behaviours by the identified resident toward other residents on at least five occasions. When asked what interventions had been put in place to protect other residents from harm prior to these incidents, they said that the resident's medication had been changed and staff were continuing to monitor the resident and intervene should they demonstrate inappropriate behaviours. The ED and DRQO acknowledged that residents were not protected from abuse by the identified resident.

The severity was determined to be a level two as there was potential for actual harm; and the scope of this issue was identified as being a pattern. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance.

During an initial tour of the home, inspectors identified the following:
- large areas where paint was chipped off railings in the hallways;
- drywall patches in the common toilet room, hallways, second floor tub room, second floor TV lounge, and dining room;
- ceiling damage in the dining room;
- black scuff marks on the elevator door, two east tub room door and walls in a number of common areas within the home;
- water damage on the counter in the second floor tub room;
- damage to corner of the elevator floor below the control buttons;
- hand railing between room L03 to L04 was observed to be in disrepair.

During Stage 1 of Resident Quality Inspection (RQI), inspectors identified the following:
- drywall patches and/or missing paint were observed on the walls in fourteen resident rooms:
- floors in disrepair were observed in three resident rooms;
- vinyl surrounding sink was observed to be in disrepair in the shared washrooms of four resident rooms;
- doors were observed to be in disrepair in four resident rooms;
- baseboard was missing in one resident room.

Maintenance staff told the inspector during an interview, that all staff were responsible for communicating paint or maintenance issues to maintenance staff via a communication book. The maintenance staff told the inspector that they prioritized all paint or maintenance issues noted in the communication binder and then provided the services required. The maintenance staff said that they did not conduct formal audits of required

maintenance jobs and that there was no official documentation regarding completed painting or drywall patching. The maintenance staff acknowledged that there were drywall patches that still required painting. In terms of the flooring, the maintenance staff told the inspector that the Executive Director was responsible for any flooring concerns.

The Director of RAI and Quality Outcomes (DRQO) told this Inspector that the Executive Director supervised maintenance staff and made approvals of maintenance work in the home. When the Executive Director was not available, the DRQO was able to make these approvals. DRQO told the Inspector that the home used to have a checklist for maintenance work that was kept in a binder and that the home tried to locate it last week but they were not successful. The DRQO acknowledged that there was no documentation or audit process surrounding routine and preventative maintenance schedules. When asked about the home's maintenance process for newly vacated resident rooms, the DRQO said maintenance staff was informed by the home during a huddle, via the communication binder, in person or via the Point Click Care homepage. The maintenance staff told the Inspector that once made aware of a newly vacated resident room, their role was to paint the room and move furniture around.

The maintenance staff told the inspector that they did not document or track the completion of freshly painted resident rooms unless there was a request made to paint them in the communication binder. They said they were waiting for a tracking form from PeopleCare to document maintenance jobs and that at the time of the inspection, there was no formal tracking form being utilized.

During a tour of the home, the DRQO and maintenance staff acknowledged the disrepair observed by inspectors during the Resident Quality Inspection. The DRQO provided this inspector with a copy of the home's policy entitled Environmental Services – Maintenance Routines – Painting (reference # 006220.00) with a review date of March 13, 2017. The policy documented that quarterly audits would be conducted throughout the home, including resident rooms, common areas and corridors, to determine painting priority list and that a painting plan would be derived from the information collected on this audit and from daily requisitions reported by staff, family and residents, and leadership walk-about inspections. The policy also documented that the Executive Director or maintenance was to review all inspection reports of all resident rooms, dining rooms, common areas, corridors etc. for necessary wall repairs and painting requirements on a monthly basis and record date of painting on the painting plan and retain these sheets in the maintenance office as proof of ongoing painting in the homes.

DRQO acknowledged that the quarterly audits outlined in the home's policy were not being completed.

The DRQO also provided this inspector with a copy of the home's "Painting Plan Record Log" which was blank. The DRQO acknowledged that the log was blank and was not being utilized by the home.

The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

The severity was determined to be a level one as there was minimal risk; and the scope of this issue was identified as being widespread affecting common areas of the home and individual resident rooms. The home's compliance history was a level three, with one or more related noncompliance in the last three years. [s. 90. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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(s) who had reasonable grounds to suspect that abuse of a resident by anyone may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

During a review of the identified resident's clinical record, a progress note stated that two staff witnessed the identified resident exhibit responsive behaviours towards another resident. The co-resident was potentially harmed by the incident and could not protect themselves. The DRQO was informed

A Critical Incident (CI) #1033-000024-16 was submitted to the Director four days following an incident in which an identified resident was observed exhibiting responsive behaviours that potentially harmed another resident.

During a review of the clinical record for the identified resident it was noted that there were three separate incidents where the resident had exhibited responsive behaviours where co-residents were either harmed or put at risk of harm.

During an interview with the Executive Director (ED) and DRQO, the ED said that they had not notified the Director of the first incident because they felt it was a one time thing. The ED stated that the reason CI 1033-000024-16 was submitted several days after the incident took place was because the home was completing their investigation to determine exactly what had happened. The ED said they were aware that incidents of abuse, whether witnessed or suspected, were to be reported to the Director immediately. They acknowledged that they were late reporting the incident of suspected abuse described in the CI 1033-000024-16, and that they failed to report the four other incidents of alleged abuse by the identified resident.

The severity was determined to be a level one with minimal risk; and the scope of this issue was identified as being widespread. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

During observations in stage 1 of the home's Resident Quality Inspection (RQI) the following was noted:

- the call bell in the shared washroom of three separate resident rooms was difficult to activate despite multiple attempts.

This inspector notified the ED that inspectors had difficulty activating the communication response systems in these shared washrooms and the ED said they would follow-up with their maintenance department.

The maintenance staff told this inspector that during a previous inspection access to the call bells in the washrooms of resident rooms on the lower level was brought forward as a concern. At that time they had to make changes with respect to the location of the pull cords in order for them to be more accessible. When the maintenance staff was told that inspectors had difficulty activating the communication response system in the identified washrooms, they said that they had checked the call bells in the identified washrooms that morning and they were working.

Observations identified that the set up for the call bells in the shared washrooms of the identified rooms were all the same. The call bell cord ran from the switch on one side of the toilet along the wall behind the toilet and then along the wall on the opposite side to where the switch was situated. The cord ran through a series of "o" rings. When the call bell cords were pulled in each of the washrooms it did not activate the communication response system. After speaking with the maintenance staff this inspector once again tried the call bells in the identified shared washrooms. Despite several attempts to activate the communication system by changing the angle of pull and adding more force, the call system would not activate. It was only after this inspector pulled with both hands that the communication response system activated.

During a tour of the shared washrooms in resident rooms on the lower level, the ED tried the call bell in one of the identified resident washrooms and was not able to activate the communication response system. The ED acknowledged that the call bells in the shared washrooms in resident rooms on the lower level were not easily used by residents as they would not have the strength to activate the communication response system.

The licensee has failed to ensure that the resident-staff communication and response system was easily used by residents at all times.

The severity was determined to be a level two, with potential for actual harm; and the scope of this issue was identified as being isolated during the course of this inspection. The home's compliance history was a level three, with one or more related noncompliance in the last three years. [s. 17. (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 the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: 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 were documented.

The home's policy entitled "Head Injury" reference number 005200.00, section "Care Monitoring" stated that as an un-witnessed head injury or neurological insult of unknown origin may cause changes in a resident's level of consciousness or responsiveness, all un-unwitnessed resident falls were to be assessed for a potential head injury. The RN /RPN were to assess the resident's level of consciousness, blood pressure, pulse, respirations and pupillary reaction. The staff were to document assessments as indicated on the Head Injury Routine form and assess as per the times on the form. The Head Injury Routine Monitoring Record was to be placed in resident's chart upon completion.

The Critical Incident (CI) 1033-000018-16 was related to an un-witnessed fall. The identified resident was found sitting on the floor. The resident had functional range of motion and clinical notes stated that a Head Injury routine was initiated. It was later

identified that the resident had sustained an injury as a result of the fall.

During a review of the clinical records for the identified resident, there was no completed Head Injury Routine form found for the resident's fall. Record review identified that the resident had two other un-witnessed falls.

A RPN reviewed the chart with the inspector and reported that the Head Injury Routine forms should be filed upon completion in the resident's chart. The RPN said they were not able to find the Head Injury Routine forms for the three un-witnessed falls sustained by the identified resident.

The Director of Care (DOC) told the inspector that it was the home's expectation that a Head Injury Routine be documented for all un-witnessed falls. The DOC acknowledged that a Head Injury Routine had not been initiated for the identified resident's most recent fall, and they were unable to find Head Injury Routines completed for the resident's two previous un-witnessed falls.

The severity was determined to be a level two with potential for actual harm; and the scope of this issue was identified as being isolated during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and
Regulations. [s. 30. (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 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 were documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a restraint by a physical device was included in the plan of care.

An identified resident was observed sitting in a wheelchair with a device applied. The resident was asked if they could remove the device and they were not able to remove it.

Review of the identified resident's clinical record identified a Fall-Risk Screening assessment which stated that the resident was a high risk to fall. The resident was identified as having had an un-witnessed fall while trying to get out of their wheelchair. The plan of care with a focus of "Falls" identified in the interventions that a device was to be applied to prevent the resident from getting out of their chair.

An occupational therapy progress note stated that a device had been introduced as a trial. Family were to be notified. There was no documentation of an assessment related to the application of the physical device including the reason for the application, alternatives trialed, Substitute Decision Maker (SDM) consent, and whether the resident was able to remove the device. Review of the most recent Minimum Data Set (MDS) assessment, identified under "Section P: Special Treatments and Procedures, 4. Devices and Restraints" that during the last seven days the resident had no devices or restraints applied.

During an interview with a Personal Support Worker (PSW), they told this inspector that the identified resident was no longer walking and required assistance from staff for transfers. When asked if they were aware of the reason that the resident had a device applied, they said that it was because the resident was at risk of falling from their wheelchair. The PSW said that it was in place as a safety measure. When asked if the resident could remove the device on their own the PSW said they could not.

During an interview with the Director of RAI and Quality Outcomes (DRQO), they said that it was the home's expectation that before any type of device was applied they would

complete a Restraint / PASD assessment. If the device was indicated they would also determine if there were restraining qualities. In this case a physicians order and consent by the SDM for application of the device would be required. The DRQO acknowledged that there was no Restraint / PASD assessment completed for the identified resident prior to the application of the device and the resident was not able to remove the device on their own. The physical device had not be included in the resident's plan of care.

The licensee failed to ensure that restraint by a physical device was included in the plan of care.

The severity was determined to be a level two with potential for actual harm; and the scope of this issue was identified as being isolated during the course of this inspection. The home's compliance history was a level three, with one or more related noncompliance in the last three years. [s. 31. (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 restraint by a physical device was included in the plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

During a review of the identified resident's plan of care, it was noted that the resident was to be monitored for the risk of responsive behaviours and specific interventions were documented.

During a review of the progress notes for the identified resident, there were ten documented incidents of responsive behaviours towards other residents during a six month period that posed a risk of harm to those residents.

During the Resident Quality Inspection, the identified resident was observed participating in a program amongst other residents. Once the program ended recreation staff were busy taking residents back to their rooms. There was a registered staff in the nursing office across from the atrium and a PSW in the hall near the atrium. At one point the identified resident was observed exhibiting responsive behaviours towards another resident. A short time later the identified resident was observed unsupervised exhibiting responsive behaviours towards anther resident. Later the same day, the identified resident was seen unsupervised for approximately ten minutes with other residents in the room.

A Personal Support Worker told inspectors that that there had been occasions when the resident's responsive behaviours had escalated. The PSW recalled an incident where they had observed the identified resident exhibit responsive behaviours that had put another resident at risk of harm. That resident was not capable of protecting themselves due to a cognitive impairment. When asked what interventions had been put in place to protect other residents from harm, the PSW said that for the first while after this incident a specific intervention was put in place but it was discontinued not long after. At present, they have been told to monitor the identified resident when they are around others that would not be able to protect themselves.

A Registered Practical Nurse (RPN) / BSO lead told the inspector that BSO had followed the identified resident with respect to their responsive behaviours a number of months ago. The RPN said there had been specific interventions put in place following one or

two incidents but some of these were discontinued when the resident had a temporary change in status. When asked what interventions remained in place to protect other residents now that the identified resident was feeling better, the RPN said that they were always monitoring the resident and if they saw the responsive behaviours they would intervene.

The ED and Director of RAI and Quality Outcomes (DRQO) told the inspector that they were aware the identified resident's first incident of responsive behaviours directed towards another resident. When asked what interventions had been put in place at that time to mitigate the risk of harm to other residents the ED shared that they felt this was likely a one time situation. The resident was referred to BSO who conducted an assessment of the resident. The DRQO acknowledged that no specific strategies or interventions were put in place at that time. The ED and DRQO were asked what new strategies were put in place after the second, very similar incident, of responsive behaviours directed towards another resident where there was potential for harm? The DRQO said that the resident's medication was changed but otherwise there were no specific interventions / strategies put in place at that time to mitigate risk to other residents. The ED and DRQO acknowledged that it was not until after a third incident of responsive behaviours potentially harming a resident, that the home put a number of strategies and interventions in place to mitigate the risk of harm to other residents in the home.

The severity was determined to be a level two with the potential for actual harm; and the scope of this issue was identified as being isolated during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 55. (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 procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), JENNA BAYSAROWICH (667), NUZHAT UDDIN (532), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2017_600568_0007
Log No. / Registre no:	007359-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 7, 2017
Licensee / Titulaire de permis :	GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home / Foyer de SLD :	GOLDEN YEARS NURSING HOME 704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karin Thomas

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

To GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all residents are protected from sexual abuse by anyone.

The licensee shall ensure that all staff in the home are aware of what constitutes sexual abuse of a resident, and that staff are provided education / training related to it's definition, consent for both cognitive and non-cognitive residents, and the staff's responsibility should they witness or suspect sexual abuse.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Critical Incident (CI) #1033-000024-16 described an incident where a Personal Support Worker witnessed an identified resident exhibited responsive behaviours towards another resident. The other resident could not cognitively or physically stop the identified resident.

CI #1033-000026-16 described an incident where staff observed the identified resident exhibit responsive behaviours towards another resident. The co-resident was observed trying to to stop them but they were not capable. When the identified resident was asked what they were doing they turned red and laughed.

During a review of the progress notes for the identified resident over a six month period there were ten incidents of responsive behaviours directed towards co-residents.

During a review of the identified resident's plan of care it was noted that the resident demonstrated responsive behaviours and specific interventions were documented.

A Personal Support Worker told inspectors that that there had been occasions when the resident's responsive behaviours had escalated. The PSW recalled an incident where they had observed the identified resident exhibit responsive behaviours that had put another resident at risk of harm. That resident was not capable of protecting themselves due to a cognitive impairment. When asked what interventions had been put in place to protect other residents from harm, the PSW said that for the first while after this incident staff were providing a specific intervention, however it was discontinued not long after. At present, they have been told to monitor the identified resident when they are around others that would not be able to protect themselves.

A Registered Practical Nurse (RPN) / BSO lead told the inspector that BSO had followed the identified resident with respect to their responsive behaviours a number of months ago. The RPN said there had been specific interventions put in place following one or two incidents but some of these were discontinued when the resident had a temporary change in status. When asked what interventions remained in place to protect other residents now that the identified resident was feeling better, the RPN said that they were always monitoring the resident and if they saw the responsive behaviours they would intervene.

During an interview with Executive Director (ED) and the Director of RAI and Quality Outcomes (DRQO) they said BSO had completed an assessment but they acknowledged that no interventions were put in place to mitigate risk to other residents at that time. The ED and DRQO were shown documentation that detailed incidents of responsive behaviours by the identified resident toward other residents on at least five occasions. When asked what interventions had been put in place to protect other residents from harm prior to these incidents, they said that the resident's medication had been changed and staff were continuing to monitor the resident and intervene should they demonstrate inappropriate behaviours. The ED and DRQO acknowledged that residents were not protected from abuse by the identified resident.

The severity was determined to be a level two as there was potential for actual harm; and the scope of this issue was identified as being a pattern. The compliance history was a level two, with one or more unrelated noncompliance

in the last three years.
(568)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall ensure that as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventive and remedial maintenance and that they are being implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance.

During an initial tour of the home, inspectors identified the following:
- large areas where paint was chipped off railings in the hallways;
- drywall patches in the common toilet room, hallways, second floor tub room, second floor TV lounge, and dining room;
- ceiling damage in the dining room;
- black scuff marks on the elevator door, two east tub room door and walls in a number of common areas within the home;
- water damage on the counter in the second floor tub room;
- damage to corner of the elevator floor below the control buttons;
- hand railing between room L03 to L04 was observed to be in disrepair.

During Stage 1 of Resident Quality Inspection (RQI), inspectors identified the following:

- drywall patches and/or missing paint were observed on the walls in fourteen resident rooms:
- floors in disrepair were observed in three resident rooms;
- vinyl surrounding sink was observed to be in disrepair in the shared washrooms of four resident rooms;
- doors were observed to be in disrepair in four resident rooms;
- baseboard was missing in one resident room.

Maintenance staff told the inspector during an interview, that all staff were responsible for communicating paint or maintenance issues to maintenance staff via a communication book. The maintenance staff told the inspector that they prioritized all paint or maintenance issues noted in the communication binder and then provided the services required. The maintenance staff said that they did not conduct formal audits of required maintenance jobs and that there was no official documentation regarding completed painting or drywall patching. The maintenance staff acknowledged that there were drywall patches that still required painting. In terms of the flooring, the maintenance staff told the inspector that the Executive Director was responsible for any flooring concerns.

The Director of RAI and Quality Outcomes (DRQO) told this Inspector that the Executive Director supervised maintenance staff and made approvals of maintenance work in the home. When the Executive Director was not available, the DRQO was able to make these approvals. DRQO told the Inspector that the home used to have a checklist for maintenance work that was kept in a binder and that the home tried to locate it last week but they were not successful. The DRQO acknowledged that there was no documentation or audit process surrounding routine and preventative maintenance schedules. When asked about the home's maintenance process for newly vacated resident rooms, the DRQO said maintenance staff was informed by the home during a huddle, via the communication binder, in person or via the Point Click Care homepage. The maintenance staff told the Inspector that once made aware of a newly vacated resident room, their role was to paint the room and move furniture around.

The maintenance staff told the inspector that they did not document or track the completion of freshly painted resident rooms unless there was a request made to paint them in the communication binder. They said they were waiting for a tracking form from PeopleCare to document maintenance jobs and that at the time of the inspection, there was no formal tracking form being utilized.

During a tour of the home, the DRQO and maintenance staff acknowledged the disrepair observed by inspectors during the Resident Quality Inspection. The DRQO provided this inspector with a copy of the home's policy entitled Environmental Services – Maintenance Routines – Painting (reference # 006220.00) with a review date of March 13, 2017. The policy documented that quarterly audits would be conducted throughout the home, including resident rooms, common areas and corridors, to determine painting priority list and that a painting plan would be derived from the information collected on this audit and from daily requisitions reported by staff, family and residents, and leadership walk-about inspections. The policy also documented that the Executive Director or maintenance was to review all inspection reports of all resident rooms, dining rooms, common areas, corridors etc. for necessary wall repairs and painting requirements on a monthly basis and record date of painting on the painting plan and retain these sheets in the maintenance office as proof of ongoing painting in the homes. DRQO acknowledged that the quarterly audits outlined in the home's policy were not being completed.

The DRQO also provided this inspector with a copy of the home's "Painting Plan Record Log" which was blank. The DRQO acknowledged that the log was blank and was not being utilized by the home.

The licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

The severity was determined to be a level one as there was minimal risk; and the scope of this issue was identified as being widespread affecting common areas of the home and individual resident rooms. The home's compliance history was a level three, with one or more related noncompliance in the last three years.
(667)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that the person(s) who had reasonable grounds to suspect that abuse of a resident by anyone may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Grounds / Motifs :

1. The licensee failed to ensure that the person(s) who had reasonable ground to suspect that abuse of a resident by anyone may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

During a review of the identified resident's clinical record, a progress note stated that two staff witnessed the identified resident exhibit responsive behaviours towards another resident. The co-resident was potentially harmed by the incident and could not protect themselves. The DRQO was informed

A Critical Incident (CI) #1033-000024-16 was submitted to the Director four days following an incident in which an identified resident was observed exhibiting responsive behaviours that potentially harmed another resident.

During a review of the clinical record for the identified resident it was noted that there were three separate incidents where the resident had exhibited responsive behaviours where co-residents were either harmed or put at risk of harm.

During an interview with the Executive Director (ED) and DRQO, the ED said that they had not notified the Director of the first incident because they felt it was a onetime thing. The ED stated that the reason CI 1033-000024-16 was submitted several days after the incident took place was because the home was completing their investigation to determine exactly what had happened. The ED said they were aware that incidents of abuse, whether witnessed or suspected, were to be reported to the Director immediately. They acknowledged that they were late reporting the incident of suspected abuse described in the CI 1033-000024-16, and that they failed to report the four other incidents of alleged abuse by the identified resident.

The severity was determined to be a level one with minimal risk; and the scope of this issue was identified as being widespread. The compliance history was a level two, with one or more unrelated noncompliance in the last three years.

(568)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 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 7th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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