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
Jul 9, 2017	2017_569508_0007	008240-17	Resident Quality Inspection

Licensee/Titulaire de permis

GRACE VILLA LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

GRACE VILLA NURSING HOME
45 LOCKTON CRESCENT HAMILTON ON L8V 4V5

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214), THERESA MCMILLAN (526)

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 26, 27, 28, May 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 2017.

During the course of this inspection the inspectors toured the home, reviewed health records, relevant policies and procedures, home's internal investigation notes, observed resident care and dining and snack service. The following Critical Incident inspections were conducted concurrently during this RQI: log # 023994-16, 005178-17, 024949-16, 014303-16, 019913-16, 028806-16, 010377-16, and 008724-17 related to allegations of abuse, 024766-16, 007324-17, 007593-17, 007935-17, 007470 -17 related to falls.

The following Complaint inspections were conducted concurrently during this RQI: log# 028664-16, 032174-16 related to denying admission, 007421-16 related to allegation of abuse, 004117-17 related to managing responsive behaviours, 033281-16 related to resident's rights.

The following Follow-up inspections were conducted concurrently during this RQI: log# 034526-16, s. 213(1) related to not having a Director of Nursing and Personal Care on-site 35 hours per week, log #034525-16, s. 212(4) related to not having a qualified Administrator, log #034527-16, s. 36 related to failing to provide safe transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Environmental Services Manager (ESM), Food Service Supervisor (FSS), Ward Clerk, registered staff, Personal Support Workers (PSWs), dietary staff, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Admission and Discharge
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
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.
- **21 WN(s)**
- **8 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (4)	CO #001	2016_250511_0013	508
O.Reg 79/10 s. 213. (1)	CO #002	2016_250511_0013	508
O.Reg 79/10 s. 36.	CO #003	2016_250511_0013	508

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 failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) According to a Critical Incident report (CI), on an identified date in 2016, resident #022 had responsive behaviours towards staff #367 while the employee was assisting the resident. Resident #022 was cognitively impaired and had a history of responsive behaviours towards co-residents and staff. It was witnessed by staff #353 that staff #367 physically abused resident #022.

The home's investigation concluded that the staff member who was a contracted employee was abusive to resident #022 and disciplinary actions were taken.

During an interview with the ADOC on May 8, 2017, it was confirmed that the employee's actions were abusive and that the resident was not protected from abuse by anyone.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #023994-16, conducted concurrently during this RQI.

B) According to a CI, on an identified date in 2016, resident #035 reported to staff that they had been physically aggressive towards resident #036 resulting in injuries to resident #036 and the resident had to be transferred to hospital for treatment.

Resident #035 indicated that the altercation occurred between the two residents due to resident #036's responsive behaviours towards resident #035 resulting in resident #035 becoming physically aggressive towards resident #036.

Internal investigative notes and an interview with the ADOC on May 17, 2016, confirmed that resident #036 was not protected from abuse by anyone.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #014303-16, conducted concurrently during this RQI.

C) On an identified date in 2016, the home submitted a Critical Incident report (CI) which alleged that on an identified date in 2016, staff #365 had removed money from resident #034's wallet, when the resident was not in attendance in their room and that this alleged incident was witnessed by resident #030.

The home notified police and investigated the incident. The home confirmed through interviews and the CI report that staff #365 had not been given permission by the resident to go into their personal belongings and that money was missing from the

resident's wallet.

An interview with the ADOC confirmed that resident #034 had not been protected from abuse by anyone.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #010377-16 that was conducted concurrently with the RQI Inspection.

D) A review of a Critical Incident (CI) submitted by the home indicated that on an identified date in 2017, resident #040 attempted to take a mobility device belonging to resident #041 and became physically aggressive towards #041, resulting in an injury to resident #041's, when resident #041 attempted to stop them from taking their mobility device.

A review of the resident's clinical record and the CI submitted by the home, indicated that the resident had demonstrated numerous incidents of verbal and physical aggression towards resident's, staff and a visitor over an identified period of time.

An interview with the ADOC confirmed that resident #041 had not been protected from abuse by anyone.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #005178-17 that was conducted concurrently with the RQI Inspection. [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. 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 failed to ensure that the resident-staff communication and response system clearly indicated when activated where the signal was coming from.

The home's resident-staff communication and response system, also known as the call bell system, consisted of pull stations that, when activated, triggered a light that illuminated in the hallway above the door of the room where a station was activated, a sound in the hallway and nursing station, and a panel display at the nursing station.

During resident observations between April 26 and 28, 2017, Long Term Care Homes (LTC) Inspector #526 observed that when 12 of 13 bed stations were activated, the light was illuminated but no sound could be heard in 12 identified rooms. In addition, on May 3, 2017, the same bed stations failed to sound when activated, and the lights above the doors of identified rooms did not illuminate in two identified rooms. During these observations, PSWs #259, #106, #108, and #156 confirmed that sound could not be heard when the resident-staff communication and response system was activated and that they may not know that the system had been activated, or where a signal was coming from.

On an identified date, resident #020 was laying in their bed and asked LTC Inspector

#526 to assist them to use the bathroom. The resident activated the resident-staff communication and response system by pulling the cord at their bed station; a light was illuminated in the hallway above their door but no sound could be heard. The LTC Inspector observed staff walk past the room as follows: housekeeper #224, the Assistant Director of Nursing (ADOC), housekeeper #224 during a duration of nine minutes after the call bell had been activated. Eleven minutes later, RPN #325 knocked on the door and asked resident #020 why they had not gotten up, closed the door and the light above the door turned off. During interview, RPN #325 stated that they did not hear the call bell sound but saw the light when they went to attend to another resident in that same hallway; they were not aware of how long the resident had been waiting. During interview, housekeeper #224 stated that they would normally assist a resident if they saw a call bell triggered, but that they were not aware that resident #020 had activated their call bell. The ADOC stated that they were not aware that resident #020 had triggered their call bell, even though they were standing outside of the resident's room.

The LTC Inspector reported to the Administrator on April 28, 2017 that the bed station call bells were not triggering a sound. During interview on May 3, 2017, the Environmental Services Manager (ESM) stated that the system should have a sound. They stated that a new surveillance monitoring system had been installed within the past three weeks that may have disrupted the resident-staff communication and response system on the third floor. They stated that staff would notify maintenance staff using the maintenance book, regarding call bells that were not functioning. The maintenance book was reviewed daily and repair of identified issues would be initiated. They reported that on an identified date resident #020's bed and bathroom stations had been identified as not functioning, were serviced and thought to be functioning. The ESM was not aware of a wide spread sound outage on the third floor that had been identified during this inspection. According to the Administrator, on May 2, 2017, PSW #321 reported to the home's Administrator, ESM and LTC Inspector #526 that if the bathroom stations were not fully cancelled, the bed stations would not activate a sound as they normally should. According to the Administrator, after PSW #253 fully cancelled all bathroom stations, all but two bed stations triggered a sound that could be heard so that staff would know where the signal was coming from. According to the Administrator, as of May 4, 2017, all bed and bathroom stations were functioning so that staff would be aware of where the signal was coming from.

During interview, the ESM confirmed that when bed stations did not trigger a sound, staff may not know that the system was activated or where the resident-staff communication and response system signal was coming from. [s. 17. (1) (f)]

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. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care home Service accountability agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in Applicable policy".

The Long-Term Care Homes Nursing and Personal Care (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care".

On May 3, 2017, nursing staff #250 was observed completing laundry duties (delivering personal laundry to resident rooms). Staff #250 verified that delivering personal laundry was a regularly assigned duty.

The Administrator also confirmed on May 3, 2017, that Personal Support Workers (PSW) are assigned the duty of laundry delivery. [s. 101. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) Resident #002 was observed to have debris in their mouth. The following day, the resident was observed to have debris which was white in colour, in their mouth between their upper teeth and between their gum line and upper teeth.

An interview with PSW staff #154 who was assigned to this resident, indicated that staff do assist the resident with their oral care by applying toothpaste onto their toothbrush. The staff member indicated that at times, the resident only required supervision to brush their teeth and other times, the resident required more assistance. The staff member also indicated that the resident has a mouthwash that staff assist with. The staff member indicated that the resident does have dentures which are removed at bedtime and soaked overnight. The staff member indicated that the resident may refuse to wear their dentures.

A review of the resident's current written plan of care had not contained any information regarding the resident's oral care needs and preferences.
An interview with the DOC and the ADOC confirmed that no written plan of care was in place that set out the oral care needs and preferences for resident #002.

B) During an interview with resident #002, it was communicated to Long Term Care (LTC Homes) Inspector #508, that the resident was woken up at 0700 hours but would like to sleep in longer.

An interview with PSW staff #154 and #201 indicated that at times staff wake the resident in the morning and other times, the resident is awake when staff enter their room. The staff indicated that sometimes the resident does want to sleep longer and may not wake up until later in the morning. Staff indicated that when the resident decides to sleep longer in the morning, they keep breakfast for when the resident wakens.
A review of the resident's current written plan of care had not contained any information regarding the resident's sleep and rest needs and preferences.

An interview with the DOC and the ADOC confirmed that no written plan of care was in place that set out the sleep and rest needs and preferences for resident #002.

C) During an interview with resident #010, the resident indicated that at times the resident is put to bed in the evening and would sometimes prefer to stay up later.

During a review of the resident's written plan of care which provides direction to staff on the resident's care needs and preferences, it was identified that the plan did not include sleep patterns or sleep preferences.

It was confirmed through review of the resident's clinical record and during an interview with the ADOC that the written plan of care for resident #010 did not set out the planned

care for the resident. [s. 6. (1) (a)]

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

A) Resident #002 was observed on two identified dates by Long Term Care Homes (LTC) Inspectors during stage one to have debris on her mouth. A review of resident #002's Medication Administration Record (MAR) for an identified month in 2017, indicated that the resident was to receive a specific treatment three times a day. An interview with PSW staff #154 on May 3, 2017, confirmed that they had not provided this specific treatment to the resident as directed in their plan.

B) A review of resident #040's clinical record indicated that the resident had a specific intervention in place in 2017, to assist in managing the resident's known responsive behaviours.

A review of progress notes documented on a specific date in the resident's clinical record indicated that this intervention had not been provided to the resident as directed.

An interview with the DOC and ADOC confirmed that the care set out in the plan of care for resident #040, was not provided to the resident as specified in their plan.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #005178-17 that was conducted concurrently with the RQI Inspection.

An interview with the DOC and the ADOC confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. [s. 6. (7)]

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

A) According to their health record resident #008 was at risk for falls and had a specific intervention in place. During this inspection, the resident indicated to the Long Term Care Homes (LTC) Inspector that this specific intervention had been discontinued without consulting with the resident which made the resident feel upset.

Review of the document the home referred to as the care plan, indicated that resident

#008 was to have this intervention in place for specific reasons at specific times. The resident had been assessed on two identified dates in 2017, at which time it was noted that the resident was at risk for falling due to a medical condition.

During observation resident #008's specific intervention had been applied, and then not applied the next day. During interview on May 3, 2017, Personal Support Worker #253 stated that they were not aware that resident #008's specific intervention had been discontinued, how their care had changed or that the plan of care had been updated. Review of the health record revealed that the plan of care had not been updated to include the discontinuation of resident #008's falls risk intervention and if any other measures were in place to assist the resident with their care needs.

During interview, the Assistant Director of Care (ADOC) reported that on April 27, 2017, they spoke with resident #008 regarding their use of this specific intervention but had not assessed the resident. At that time the ADOC determined that this intervention was not needed and instructed staff to discontinue it. The ADOC stated that they did not reaassess the resident and that the plan of care was not updated when the intervention was discontinued. [s. 6. (10) (b)

B) Resident #016 was admitted to the home on an identified date in 2017, and was assessed as being continent of their bladder and bowels. The resident had a change in condition and a decline in their continence. The resident was reassessed and it was identified during the observation period that the resident was occasionally incontinent for bowel and frequently incontinent for bladder.

A review of the resident's current written plan of care indicated that the plan had not been updated to reflect the resident's change in their bowel continence and there were no interventions to manage the resident's bowel incontinence.

It was confirmed during an interview with the ADOC and the DOC on May 8, 2017, that the resident's plan of care was not reviewed and revised when the resident's care needs changed.

C) During the Resident Quality Inspection (RQI), resident #009 was observed to have altered skin integrity on a specific area on their body.

An interview with registered staff #100, indicated that the resident does have a history of altered skin integrity that come and go. Staff #100 confirmed that no plan or treatment

was in place to manage the resident's current, altered skin integrity. Staff #100 confirmed that the plan of care had not been reviewed and revised when the resident's care needs changed.

D) A review of a Critical Incident (CI) that was submitted by the home, indicated that on an identified date in 2017, resident #043 sustained an unwitnessed fall. The resident was transferred to hospital and it was confirmed that the resident sustained injuries.

A review of the resident's current written care plan indicated under the transfer focus, that the resident was to be transferred using the Maxi lift with two persons assistance and that the resident could not weight bear. The resident's care plan indicated under the mobility focus that the resident was dependent in their wheelchair and that the wheelchair was required for all modes of transportation. Staff were to assist the resident with pushing their wheelchair. A review of the resident's fall focus indicated to ensure that the resident's bed was at a comfortable height for the resident to access in and out with ease; indicated to encourage the resident to use assistive devices properly and also indicated to transfer and change positions slowly.

An interview with the DOC and ADOC confirmed that the resident's plan of care was not reviewed and revised for all of their care needs when the resident sustained a significant change in their health status as a result of a fall with injury.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #007935-17 that was conducted concurrently with the RQI Inspection. [s. 6. (10) (b)]

4. The licensee failed to ensure that when the resident was reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A) Resident #022 exhibited identified responsive behaviours towards co-residents and staff. A review of the resident's clinical record indicated that the resident was regularly involved in resident to resident altercations.

It was identified that the resident required constant reminders and monitoring to minimize the risk of altercations. Interventions had been developed and implemented to manage the resident's responsive behaviours including increased monitoring; however, the resident continued to have resident to resident altercations.

During an interview with the Assistant Director of Care (ADOC) on May 8, 2017, the ADOC indicated that an additional intervention had not been considered and although the resident was on increased monitoring, the resident continued to have altercations with co-residents.

It was confirmed during an interview with the ADOC that when the care set out in the plan of care had not been effective, different approaches were considered in the revision of the plan of care.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #004117-17 inspected concurrently during this RQI.

B) During an observation of resident #013, it was identified by LTC Homes Inspector #526 that the resident's nails were long with debris noted under the resident's nails. A review of the resident's clinical record indicated that the resident had regularly refused his scheduled showers and nail care.

Resident #013 had identified responsive behaviours and interventions were implemented. A review of the resident's clinical record indicated that specific interventions were developed to manage these behaviours.
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During an interview with staff #192, the staff indicated that the resident continued to exhibit some identified responsive behaviours even with the use of current interventions. It was confirmed during an interview with the ADOC on May 8, 2017, that the care set out in the plan was not effective and different approaches were not considered in the revision of the plan of care. [s. 6. (11) (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 the following: that there is a written plan of care for each resident that sets out the planned care for the resident, that the care set out in the plan of care is provided to the resident as specified in the plan and that the plan of care is reviewed and revised because care set out in the plan is not effective and different approaches considered in the revision of the plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with O. Reg. 79/10 section 90. (1) that required the home to have schedules and procedures in place for routine, preventive and remedial maintenance, the licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

"Maintenance of Building Equipment" policy section 2-42, dated October 2010, indicated that the policy was designed "To ensure there is a formal process for reporting equipment

or building repairs requiring maintenance….Maintenance Log Books are located at each nurses station, laundry room, and outside of the kitchen…Task and location of problem are written in the book by the person identifying the problem."

The home's resident-staff communication and response system, also known as the call bell system, consisted of pull stations that, when activated, triggered a light that illuminated in the hallway above the door of the room where a station was activated, a sound in the hallway and nursing station, and a panel display at the nursing station.

During resident observations between April 26 and 28, 2017, Long Term Care Homes (LTC) Inspector #526 observed that when 12 of 13 bed stations were activated, the light was illuminated but no sound could be heard in 12 identified rooms. In addition, on May 3, 2017, the same bed stations failed to sound when activated, and the lights above the doors of two identified rooms did not illuminate. During these observations, PSWs #259, #106, #108, and #156 confirmed that sound could not be heard when the resident-staff communication and response system was activated in three identified rooms and that they may not know that the system had been activated, or where a signal was coming from.

On May 3, 2017, the Environmental Services Manager (ESM) toured the third floor with LTC Inspector #526, activated at least seven bed stations and found that they did not triggering an audible sound to alert staff where the sound came from. The ESM reported that they were not aware that the resident-staff communication and response system was malfunctioning in several rooms on the third floor. However, they reported that they were alerted on April 25, 2017, to an identified room's bed and bathroom stations malfunctioning and the issue was thought to be repaired on that day. They stated that they relied on care staff to notify maintenance staff in person or through the Maintenance Log Book in each home area.

Review of the third floor Maintenance Log book revealed that no entries had been made between April 26 and 28, 2017 regarding bed stations malfunctioning in three identified rooms when PSWs #259, #106, #156 and #108 confirmed that bed station call bells in these rooms were not triggering an audible sound. Personal support worker #300 confirmed that there were no entries regarding malfunctioning call bells in these identified rooms.

The ESM confirmed that if staff were aware of a malfunctioning call bell they should have notified the maintenance staff personally or by using the Maintenance Log Book,

according to the home's policy. [s. 8. (1)]

2. In accordance with O. Reg. 79/10 section 50(1) which requires every licensee of a long-term care home to ensure that the skin and wound care program must, at a minimum, provide for the provision of routine skin care to maintain skin integrity and prevent wounds; strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents; strategies to transfer and position residents to reduce and prevent skin breakdown and reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids and treatments and interventions, including physiotherapy and nutrition care.

A review of the home's policy titled, "Skin and Wound Management", dated November 2015 in the manual titled, "Nursing", stated the following:

i) Each home shall have written policies for all aspects of the management of skin care (including care of the skin, nails, feet and mouth). These shall include, but not be limited to: care provider roles and responsibilities; assessments (type/frequency/clinical tools used/wound staging); referrals.

During the Resident Quality Inspection (RQI), resident #012 was observed to have altered skin integrity on specific areas on their body. A review of the resident's clinical record had not identified this alteration in their skin integrity.

An interview with staff #313 on May 9, 2017, confirmed that they had observed the resident's altered skin integrity this day as well as in the previous week; however, had not documented these observations in the Point of Care (POC) tasks or reported their observations to registered staff.

An interview with the DOC on May 9, 2017, confirmed that the home did not have a written policy for the management of skin care in relation to the front line staff roles and responsibilities. The DOC confirmed that the home's expectations are that staff were to document any alteration to the resident's skin integrity in the Point of Care tasks and report the observation to registered staff. [s. 8. (1) (a),s. 8. (1) (b)]

3. In accordance with O.Reg 79/10 section 136. (2) 1 that required the home to have a policy that drugs that were to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that were available for administration to a resident until the destruction and disposal occurs.

A) The home's "Drug Destruction and Disposal" policy section 5-4, dated February 2017 directed staff as follows: "The nurse who processes a discontinued or a monitored medication requiring disposal is responsible for removing the medication(s) storage during shift count"; "Retain the medications in the double-locked wooden box, in the locked medication room, separate from those medications available for administration to a resident"; and "Only active narcotic and controlled orders are to be stored in the cart narcotic bin".

On May 9, 2017, LTC Inspector #526 observed discontinued controlled substances stored in the locked box in the medication cart for the east wing of the third floor as follows:
i) 14 tablets of a specific medication prescribed to resident #029;
ii) 14 tablets of a specific medication and 14 tables of another medication prescribed to resident #030.

During interview, RPN #325 stated that while residents #029 and #030 were in hospital, these medications were not administered, needed to discarded, and were counted at each shift change until they could bring the medications down to the Director of Care. Review of the "Shift Change Monitored Medication Count" sheet revealed that registered staff had discarded the controlled substances as of May 7, 2017 and that they continued to be stored with controlled medications that were currently being administered. During interview, the Director of Care (DOC) stated that staff may need to count and store the discarded controlled substances in their medication cart for up to one week before they bring them to the DOC for storage and destruction. The DOC confirmed that the home's policy had not been complied with when staff stored controlled substances for destruction in the medication cart locked box with medications that were being administered.

B) The home's "Drug Destruction and Disposal" policy section 5-4, dated February 2017 directed staff as follows: "Securely store surplus medication in the designated Stericycle container in a locked area within the home only accessible to nursing staff. The surplus medication container is separate from drugs that are available for administration to a resident and kept in the home until the licensed medical waste disposal company picks up the containers".

On May 10, 2017, the home's ward clerk opened the storage room at the end of the first floor west hall where Long Term Care Homes (LTC) Inspector #526 observed both non-controlled medications and denatured controlled medications stored in an open

transparent bag within a red bag and cardboard box. During interview, the Director of Care (DOC) confirmed that all medications for destruction and removal were stored in this room until the medical waste disposal vendor could come to the home to remove them. They confirmed that the room was not accessible only to nursing staff since the home's ward clerk, office manager and Environmental Services Manager had access as well. The DOC confirmed that the manner in which discarded medications were stored in the home did not comply with the "Drug Destruction and Disposal" policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is to ensure that any plan, policy, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident was assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44.

A review of a Critical Incident report (CI) submitted by the home indicated that on an

identified date in 2017, resident #040 attempted to take a mobility device belonging to resident #041 and became physically aggressive towards #041 which resulted in an injury to resident #041, when resident #041 attempted to stop them from taking their mobility device.

A review of resident #040's clinical record indicated that the resident was admitted to the home on an identified date in 2013. The resident's clinical record and the CI submitted by the home, indicated that the resident had demonstrated numerous incidents of responsive behaviours towards resident's, staff and a visitor over a time period from August 26, 2013 up to March 4, 2017.

A review of a paper admission assessment completed by the home and titled, "Comprehensive Admission Assessment", indicated that the resident demonstrated present behaviours that included swearing at staff and wanting to leave and past behaviours of pushing and grabbing co-residents and staff. A review of a progress note documented on an identified date titled, "Moving in Note", indicated under "Emotional state", that the resident had a history of verbal and physical aggression with co-residents and staff and did not like when they entered their personal space and that the resident copes better with one step commands and cuing.

A review of the Community Care Access Centre (CCAC) Behavioural Assessment Form and Medical report which was contained in the CCAC Long Term Care Home Application Form and respectively dated July 30, 2013 and July 22, 2013, indicated that the resident had a history of verbal and physical aggressive behaviours and had a history of demonstrating the potential for injury to self or others.

A review of the resident's initial plan of care indicated that goals and interventions to manage the resident's verbal and physical responsive behaviours and to minimize the risk of altercations to residents, staff and others, had not been implemented until August 27, 2013, the day following an incident in which resident #040 had demonstrated physical and verbal aggression towards a co-resident and staff.

An interview with the ADOC confirmed that the initial plan of care for resident #040 had not been developed within 24 hours and based on the home's admission assessment and on the assessment and information provided by the placement co-ordinator in relation to the resident's history of responsive behaviours and potential for injury to their self or others.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #005178-17 that was conducted concurrently with the RQI Inspection. [s. 24. (4)]

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 when a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours strategies were developed and implemented to respond to these behaviours, where possible.

Resident #005 exhibited responsive behaviours which included verbal and physical aggression, resistive to care and wandering.

A review of the resident's quarterly Minimum Data Set (MDS) coding dated March 22, 2017, indicated under section E. Mood and Behaviour Patterns that the resident was coded as demonstrating wandering and was resistive to care one to three days during the seven day observation period.

A review of the resident's clinical record revealed that there was no Resident Assessment Protocol (RAP) for these responsive behaviours and the written plan of care did not include any strategies to respond to the resident's behaviours of wandering or being resistive to care.

It was confirmed during an interview with the Resident Assessment Instrument (RAI) Co-ordinator on May 15, 2017, that strategies had not been developed and implemented to respond to the resident demonstrating responsive behaviours. [s. 53. (4) (b)]

2. A review of resident #012's quarterly Minimum Data Set (MDS) coding dated April 5, 2017, indicated under section E. Mood and Behaviour Patterns that the resident was coded as demonstrating wandering and verbally abusive behaviours that had occurred one to three days in the last seven days and that these behaviours were easily altered. The coding identified that the resident's behavioural status had deteriorated as compared to their status 90 days prior.

An interview with registered staff #149 and PSW staff #154 and #344, confirmed that the resident had demonstrated wandering and verbally abusive responsive behaviours in the last three months by yelling out and cursing towards staff.

A review of the resident's written care plan indicated that no strategies had been developed and implemented to respond to the resident's identified wandering and verbally abusive responsive behaviours.

An interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that strategies were not developed and implemented to respond to the resident's identified responsive behaviours. (Inspector #214). [s. 53. (4) (b)]

Additional Required Actions:

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

WN #8: 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 failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were 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.

A review of a Critical Incident report (CI) submitted by the home indicated that on March 4, 2017, resident #040 attempted to take a mobility device belonging to resident #041 and physically abused resident #041 resulting in minor injuries to resident #041 when resident #041 attempted to stop them from taking their mobility device.

A review of resident #040's clinical record indicated that the resident was admitted to the home on an identified date in 2013. The resident's clinical record and the CI report submitted by the home, indicated that the resident had a history of responsive behaviours and had demonstrated several incidents of aggression towards resident's, staff and a visitor over an identified period of time time which had resulted in either harm or a risk of harm.

A review of resident #040's written plan of care from their admission to the date of this inspection and confirmed with the ADOC, identified that procedures and interventions were not developed and implemented to assist residents, staff and others who were at risk of harm or who were harmed as well as to minimize the risk of altercations and potentially harmful interactions, each time the resident demonstrated verbal and physical responsive behaviours.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #005178-17 that was conducted concurrently with the RQI Inspection. [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 are developed and implemented to assist residents and staff who are at risk of harm or who were 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, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's process to report and locate residents' lost clothing and personal items was developed and implemented.

During interviews on April 28 and May 2, 2017, residents #003, #011, and #015 stated that they had reported to staff that they had clothing go missing in the laundry within the past month and the clothing was still missing. On May 8, 2017, resident #011 stated that on May 8, 2017, they provided a description to PSW #231 of two items of clothing that had gone missing in the laundry. During interview, PSW #231 confirmed that they were aware and reported the clothing to laundry staff #145. PSW #231 reported that they had not looked for the items of clothing on the home area, but did look in the lost and found.

They did not report the missing clothing to a registered staff or other PSW staff and did not complete any documentation to record that resident #011 had reported missing clothing.

According to interviews with the Environmental Services Manager (ESM), the home's process for reporting and locating lost clothing in the home involved staff being notified, looking in the home area for the missing clothing item, completing the "Grace Villa Missing Articles Report Sheet", notifying the ESM who would verbally notify the laundry staff, and then leave the completed form with the Administrator.

Review of the home's "Lost and Found" unnumbered policy, effective July 2013, "where the item is clothing, the laundry department and other units will be asked to watch for the lost item"; "all inquiries for lost and found articles should be referred to the Administration office"; and "Reasonable efforts will be made to find the owner of items found".

During interview on May 8, 2017, laundry staff #145 stated that since missing laundry had been a problem in the home, as of April 5, 2017, they began documenting when they found an unlabelled piece of clothing or when they were notified by a staff, resident or family member that an item of clothing had gone missing. They had documented resident #003's missing laundry on April 15, 2017, but was not aware that residents #011 and #015 had missing laundry within the past month. During interview on May 9, 2017, laundry staff #145 stated that on May 8, 2017, PSW #231 informed them of missing clothing belonging to another resident and not belonging to resident #011. They confirmed that missing laundry belonging to resident had not been entered into their lost and found log book. Laundry staff #145 stated that normally, they would conduct a search for the item in the laundry area. They also stated that they had never seen a "Grace Villa Missing Articles Report Sheet" form and had never completed one when a resident or family had come looking for an item of clothing.

During interview on May 8, 2017, the Administrator confirmed that staff did not follow the home's process to report and locate resident #011's missing clothing. [s. 89. (1) (a) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's process to report and locate residents' lost clothing and personal items are developed and implemented, to be implemented voluntarily.

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Review of resident #033's health records and a printed electronic medication incident report, revealed that on an identified date in 2017 at a specific time, the resident was administered resident #040's medications in error by Registered Nurse #500 who was contracted to work in the home by an outside vendor. Review of progress notes did not indicate any negative outcomes as a result of the incident. The Assistant Director of Care confirmed that resident #033 had been administered medication that had not been prescribed to them. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Review of the home's management of medication incidents involving resident #032 revealed that on a specific date in 2017, their prescribed medication was not administered on two occasions by a nursing student who was supervised by Registered Practical Nurse (RPN) #166; the home's electronic medication record (eMAR) confirmed this. According to the medication incident form and interview with the Assistant Director of Care (ADOC), the incident was reported. There was no entry in the progress notes about this incident, any immediate actions taken to assess and maintain the resident's health, or if the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident were notified.
The Director of Care (DOC) and the ADOC confirmed this.

B) Review of resident #033's health records and a printed electronic medication incident report in 2017, revealed that on a specific date in 2017, the resident was administered resident #040's medications in error.

Progress notes revealed that a physician, the resident, and the resident's substitute decision maker (SDM) were notified. The attending physician ordered staff to monitor the resident for potential side effects that night. The ADOC stated they were acting Director of Care at the time of the incident and were notified of the incident. However, they could not verify if the Medical Director, or the person who prescribed the medication were notified. [s. 135. (1)]

2. The licensee failed to ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b)

i) Review of resident #033's health records and a printed electronic medication incident report revealed that on a specific date in 2017, the resident was administered resident #040's medications in error by Registered Nurse #500 who was contracted to work in the home by an outside vendor. Review of the Medication Incident Final Report for this incident did not include whether any corrective action had been taken. An interview with the Assistant Director of Care (ADOC) who was the acting DOC at the time of the

incident revealed that the human resource vendor was informed about the medication incident but no further corrective action was taken in the home.

ii) In addition, Clinical Consultant Pharmacy Quarterly Reports dated June 21, 2016, September 20, 2016, December 20, 2016 and May 12, 2017 revealed that 20 medication incidents occurred in the home between March 2016 and April 2017. The ADOC and DOC stated that they were unable to provide 17 of these reports stating that the reports had been submitted electronically using a vendor application that could not be accessed. They could not verify if the incidents had been reviewed and analyzed or if corrective action had been taken. The DOC confirmed that not all medication incident and adverse reaction reports were kept in the home. [s. 135. (2)]

3. The licensee failed to ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b).

Review of the home's Clinical Consultant Pharmacist Quarterly Reports dated June 21, 2016, September 20, 2016, and December 20, 2016, indicated that medication incidents were listed but without accompanying notes about changes and improvements or their implementation. During interview on May 12, 2017, the home's Clinical Consultant Pharmacist stated that review of medication incidents and adverse reactions took place as part of the home's quarterly medication management system evaluation during Professional Advisory Committee (PAC) meetings; these discussions should have been documented in these meeting minutes.

PAC meeting minutes were provided for meetings held on May 10, June 21 and December 20, 2016; the pharmacist and DOC could not verify if the home had a PAC meeting in September 2016. These were reviewed with the home's Director of Care who confirmed that the review and discussions about changes and improvements identified and implemented had not been documented or kept in the home. In addition, they confirmed that the medication management system including medication incidents and adverse drug reactions that occurred between January 1, 2017 and May 12, 2017 had not been discussed or evaluated since there had not been a PAC meeting in 2017. [s. 135. (3)]

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) all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b)
and to ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions,
(b) any changes and improvements identified in the review are implemented, and
(c) a written record is kept of everything provided for in clause (a) and (b)., to be implemented voluntarily.

WN #12: 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 failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy 'Prevention, Elimination and Reporting of Abuse' under the section titled protocol for reporting allegations of resident abuse, indicated that the Administrator/Director of Nursing/delegate will ensure the Ministry of Health and Long Term care is notified via telephone and shall complete a Critical Incident System (CIS) report.

On an identified date in 2016, it was witnessed by employee #353 that an employee physically abused resident #022 when the resident exhibited a responsive behaviour towards staff #367. A review of the CI report completed by the home indicated that the incident was not reported to the Director until three days later.

It was confirmed by the ADOC and the DOC on May 10, 2017, that the written policy that promoted zero tolerance of abuse and neglect of residents was not complied with.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #023994-16, conducted concurrently during this RQI. [s. 20. (1)]

2. On an identified date in 2016, the home submitted a Critical Incident report (CIS) which alleged that staff #365 had removed money from resident #034's wallet and that this alleged incident was witnessed by resident #030.

The home notified police and investigated the incident. The home confirmed through interviews and the CI report that staff #365 had not been given permission by the resident to go into their personal belongings and that a sum of money was missing from the resident's wallet.

A review of the home's policy, titled, Prevention, Elimination and Report of Abuse (Administration Manual-section 2-07 and dated with an effective date of November 1, 2013) indicated the following:

i) The Abuse Decision Trees will also outline all steps needed to be taken within the home for Ministry notification as well. The abuse decision tree enclosed in this policy and titled, "Licensee Reporting of Financial Abuse", stated, "Licensee to immediately report suspicion & information to Director".

ii) Under the "Protocol for Reporting Allegations of Resident Abuse": The Administrator/Director of Nursing/ delegate will ensure the Ministry of Health and Long Term Care is notified via telephone and shall complete a Critical Incident (CI) report via the ltchomes.net website as required.

iii) Under the "Protocol for Reporting Allegations of Resident Abuse": For incidents that meet the criteria for reporting to the Police or MOHLTC, time and date of notification will be documented in the resident chart(s).

iv) Under "Protocol for Investigating Allegations of Resident Abuse by an Employee/Student/Volunteer", the policy indicated the following: The staff member receiving the initial report shall ensure that all information is documented in the resident's chart in chronological order.

A review of the CI report identified that the alleged incident occurred on an identified date in 2016. The date and time that this incident was first reported to the Director was four days later. A review of the resident's clinical record indicated that this allegation of financial abuse as well as the time and date that the police or MOHLTC had been notified, had not been documented in the resident's clinical record.

An interview with the ADOC confirmed that the home had not complied with their abuse policy in relation to the required reporting time frames to the MOHLTC as well as documentation of the incident in the resident's chart including time and date that the police and the MOHLTC were notified.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #010377-16 that was conducted concurrently with the RQI Inspection. [s. 20. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Resident #036 had identified responsive behaviours related to their diagnosis which included being aggressive towards co-residents. A review of the resident's clinical record indicated that the resident had a responsive behaviour plan; however, there was no behavioural assessment and no Resident Assessment Protocol (RAP) completed.

It was confirmed during an interview with the ADOC on May 17, 2017, that the resident's plan of care was not based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #014303-16, conducted concurrently during this RQI. [s. 26. (3) 5.]

WN #14: 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 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.

A review of resident #002's clinical record over a 14 month period, indicated that the resident had been assessed as being at a high risk for falling on their Fall Risk Assessments. A review of the resident's written care plan under interventions to manage their falls, indicated that staff would check the resident every 30 minutes during their peak fall time as the resident voids frequently at specific times. An interview with registered staff #269 confirmed that the staff do check the resident every 30 minutes during this time. Staff #116 and #269 confirmed that this information was to be documented in the Point of Care (POC) documentation system and that a task had not been created in this system to document these actions.

PLEASE NOTE: This non-compliance was issued as a result of a Critical Incident System Inspection #024766-16 that was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 30. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

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

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. On two separate dates in 2016, the home provided a written letter indicating that their acceptance for admission for applicant #019 had been declined because the resident had specific needs that the home was not able to manage at that time.

The Director of Care (DOC) and Assistant Director of Care (ADOC) in the home at the time of this inspection stated that after reviewing the records provided to the home in 2016, they noted that while applicant #019 had exhibited responsive behaviours earlier in 2016, their plan of care had been updated and they had not been exhibiting behaviours at the time of application. The DOC stated that they could not locate an assessment that identified the facility requirements or resident needs that had been identified in the refusal letter.

During interview the complainant/Community Care Access Centre Case (CCAC) worker indicated that information provided to the home did not include some of the resident's specific needs. The home's refusal of admission was provided after the home received information about the applicant's past social history.

The reason for this refusal did not meet the grounds for withholding approval as specified in the legislation, 2007, c. 8, s.44. (7).

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #032174-16 that was conducted concurrently with the RQI Inspection. [s. 44. (7)]

2. The licensee failed to ensure that an application for admission was approved unless, (a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant`s care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

On an identified date in 2016, the home provided a written letter indicating that their acceptance for admission for applicant #031 had been declined because the applicant had specific medical needs that the home would not be able to manage. The reason for this refusal did not meet the grounds for withholding approval as specified in the legislation, 2007, c. 8, s.44. (7).

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #028664-16 that was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 44. (7)]

3. The licensee failed to ensure that when they withheld approval for admission, the persons described in subsection (10): 1. The applicant; 2. The Director; 3. The appropriate placement co-ordinator, were given written notice that set out, a) the ground or grounds on which the licensee was withholding approval; (b) a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justified the decision to withhold approval; and (d) contact information for the Director.

A) On an identified date in 2016, the home provided a written notice to the Community Care Access Centre (CCAC), indicating that the acceptance of admission for applicant #031, had been declined.

An interview with the ADOC confirmed that no records could be located that this written notice of admission decline had been given to the applicant and the Director.

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #028664-16 that was conducted concurrently with the RQI Inspection.

B) On two separate dates in 2016, the home provided a written notice to the Community Care Access Centre (CCAC), indicating that the acceptance of admission for applicant #019, had been declined. An interview with the ADOC confirmed that no records could be located that this written notice of admission decline had been given to the applicant and the Director.

PLEASE NOTE: This non-compliance was issued as a result of a Complaint Inspection #032174-16 that was conducted concurrently with the RQI Inspection. [s. 44. (9)]

WN #16: 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 failed to ensure that the resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #016 was admitted to the home on an identified date in 2017. A review of the resident's clinical record indicated that staff assessed the resident using the home's continence assessment tool in Point Click Care (PCC) as being continent for both bowel and bladder.

Approximately a month after the resident was admitted, the resident had a change in condition and a decline with their continence. A review of the progress notes indicated that the resident became occasionally incontinent for bowel and frequently incontinent for bladder.

Further review of the resident's clinical record verified that the resident did not receive an assessment at the time of the resident's change in continence.

It was confirmed during interview with the ADOC and the DOC on May 11, 2017, that an assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

WN #17: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, food and fluids being served at a temperature that was both safe and palatable to the residents.

It was observed on April 26, 2017, during the lunch dining service that six lunch trays were being put together for residents sitting outside of the dining room.

The minestrone soup had been poured into bowls and placed on the trays. The trays were sitting uncovered outside of the servery on a cart for greater than 15 minutes.

During an interview with the Food Services Supervisor (FSS), it was confirmed that the soup should not have been put onto the uncovered tray until staff were ready to serve the trays to the residents to ensure it was served at the proper temperature. Staff discarded the soup as it would not have been palatable to residents.

It was confirmed through observation and during interviews that the food and fluids were not served at a temperature that was both safe and palatable to the residents. [s. 73. (1) 6.]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances were labelled properly and kept inaccessible to residents at all times.

During initial tour of the home on April 26, 2017, Long Term Care Homes (LTC) inspector #526 noted hazardous materials that were accessible to residents as follows:

1) In the unlocked cupboard beneath the sink of the servery located in the first floor dining room:
a) Suma Quat D4 Sanitizer: MSDS# MS0100419

b) Emerel multi surface creme cleaner: MSDS# MS0300056; causes eye and skin irritation, may cause irritation to mouth, throat and stomach

Residents were observed walking and sitting near the servery. Dietary Aide #132 stated that the cupboard was broken and the key did not always work when locking the cabinet. They stated that the cupboard was not locked during the day shift since staff were using the chemicals to clean the carts and the sink. They attempted to lock the cupboard three times before it locked so that the hazardous substances were not accessible to residents. The cupboard was noted to be unlocked on May 3, 2017 and the Suma Quat and Emerel substances were inside. Dietary Aide #322 confirmed that the cupboard did not lock properly and that hazardous substances were accessible to residents. The cupboard was unlocked on May 4, 2017 and contained only the Emerel cleaner.

2) In the unlocked maintenance storage room at the end of the west hallway on the first floor:
a) Virex II 256 One Step Disinfectant Cleaner and Deodorant: MSD MS03000585; Corrosive, causes skin and eye burns, harmful if swallowed, combustible liquid and vapor

b) Bravo Heavy Duty Low Odor Stripper: MSD MS03000209; Corrosive, causes skin and eye burns, harmful or fatal if swallowed
c) Shiner Spray Buff: SDS MS0800410; May cause allergic skin reaction

At the time of this observation, residents were observed sitting and walking at the east end of the hallway. The Environmental Services Manager (ESM) was walking by and reported that the door should have been locked and closed, and needed adjusting. They confirmed that the hazardous substances located inside the maintenance storage area were accessible to residents and may pose a risk to their safety.

3) In the unlocked cupboard beneath the sink in the chapel on the first floor:
a) Sporicidal Hard Surface Disinfectant: MSDS # MS0301065, Product Code: 5728148, causes skin and eye burns

The ESM reported that this cleaner was used to clean surfaces during outbreaks, was no longer in use in the home, should not have been stored in the chapel cupboard and removed it.

During interview the ESM confirmed that hazardous substances were not inaccessible to residents at all times when they were stored in an unlocked maintenance storage room

on April 26, 2017; in the unlocked cupboard of the first floor dining room servery on April 26, May 3, and 4, 2017; and in the unlocked cupboard in the chapel on April 26, May 3, and May 4, 2017. [s. 91.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an observation of a shared resident room on May 2, 2017, a container of a prescribed cream with resident #001's name on it, was observed to be sitting on the bathroom counter. This bottle contained a prescription number. A review of the resident's Treatment Administration Record (TAR) indicated that the treatment was applied by PSW staff at a specific time. An interview with registered staff #269 confirmed that the PSW staff do apply this prescribed treatment cream. The registered staff confirmed that the treatment cream was to be stored in containers which are kept locked in the clean utility room and were not to be left in the resident's room. [s. 129. (1) (a) (ii)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that before discharging a resident under O.Reg.79/10, s.145 (1), they provided a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

Resident #022 was discharged from the home on an identified date in 2017, due to a increase in the resident's responsive behaviours.

During an interview with the DOC and the ADOC on May 5, 2017, they indicated that the home could not provide a secure environment for the resident and it had been determined that the resident would better benefit from a long term care home with a secured area and with less co-residents.

The home's management team discussed the concerns with the resident's Power of Attorney (POA) however; only a verbal notice was given to the POA regarding the discharge, no written notification.

It was confirmed during an interview with the DOC and the ADOC on May 11, 2017, that a written notice to the resident`s Substitute Decision Maker (SDM) setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident`s condition and requirements for care, that justified the licensee`s decision to discharge the resident had not been provided.

PLEASE NOTE: This area of non compliance was identified during a complaint inspection, log #004117-17 conducted concurrently during this RQI. [s. 148. (2) (d)]

WN #21: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

During stage one observations, it was identified that in the bathroom shared by four residents, a bedpan, a urine collector with yellow stains and a denture cup filled with water were observed to have no label to identified who these personal items belonged to. In another shared bathroom, a used hairbrush and kidney basin (K-basin) were observed on the bathroom counter with no labels. In another identified room, an unlabelled bedpan was observed and a drinking glass and two urine collectors were also observed in bathrooms shared by four residents were all unlabeled.

During an interview with the Assistant Director of Care (ADOC) on April 27, 2017, the ADOC indicated that all resident's personal items kept in resident's shared bathrooms should be labeled to decrease risk of cross contamination.

It was confirmed through observations and during an interview with the ADOC that staff did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Issued on this 12th 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) :	ROSEANNE WESTERN (508), CATHY FEDIASH (214), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2017_569508_0007
Log No. / Registre no:	008240-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 9, 2017
Licensee / Titulaire de permis :	GRACE VILLA LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	GRACE VILLA NURSING HOME 45 LOCKTON CRESCENT, HAMILTON, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kate MacDonald

To GRACE VILLA LIMITED, 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 do the following:
1) ensure that all residents are protected from abuse, including resident #034, #041 and #036,
2) ensure that all residents who exhibit responsive behaviours of physical aggression or who have potential to harm co-residents have interventions in place to minimize the risk of abuse towards co-residents,
3) develop and implement a plan to ensure that these interventions are reviewed at least quarterly and after any near miss or actual incident of resident to resident abuse to ensure the effectiveness of these interventions.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is a pattern (2), the severity of the non-compliance has actual harm (3) and the history of non-compliance under Long-Term Care Homes Act, 2007, s.19(1) is ongoing (4) with a compliance order previously issued January 27, 2016.

The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) According to a Critical Incident report (CI), on an identified date in 2016, resident #022 had responsive behaviours towards staff #367 while the employee was assisting the resident. Resident #022 was cognitively impaired and had a history of responsive behaviours towards co-residents and staff. It was witnessed by staff #353 that staff #367 physically abused resident #022.

The home's investigation concluded that the staff member who was a contracted employee was abusive to resident #022 and disciplinary actions were taken.

During an interview with the ADOC on May 8, 2017, it was confirmed that the employee's actions were abusive and that the resident was not protected from abuse by anyone.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #023994-16, conducted concurrently during this RQI.

B) According to a CI, on an identified date in 2016, resident #035 reported to staff that they had been physically aggressive towards resident #036 resulting in injuries to resident #036 and the resident had to be transferred to hospital for treatment.

Resident #035 indicated that the altercation occurred between the two residents due to resident #036's responsive behaviours towards resident #035 resulting in resident #035 becoming physically aggressive towards resident #036.

Internal investigative notes and an interview with the ADOC on May 17, 2016, confirmed that resident #036 was not protected from abuse by anyone.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log #014303-16, conducted concurrently during this RQI.

C) On an identified date in 2016, the home submitted a Critical Incident report (CI) which alleged that on an identified date in 2016, staff #365 had removed money from resident #034's wallet, when the resident was not in attendance in their room and that this alleged incident was witnessed by resident #030.

The home notified police and investigated the incident. The home confirmed through interviews and the CI report that staff #365 had not been given permission by the resident to go into their personal belongings and that money was missing from the resident's wallet.

An interview with the ADOC confirmed that resident #034 had not been protected from abuse by anyone.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident

Inspection #010377-16 that was conducted concurrently with the RQI Inspection.

D) A review of a Critical Incident (CI) submitted by the home indicated that on an identified date in 2017, resident #040 attempted to take a mobility device belonging to resident #041 and became physically aggressive towards #041, resulting in an injury to resident #041's, when resident #041 attempted to stop them from taking their mobility device.

A review of the resident's clinical record and the CI submitted by the home, indicated that the resident had demonstrated numerous incidents of verbal and physical aggression towards resident's, staff and a visitor over an identified period of time.

An interview with the ADOC confirmed that resident #041 had not been protected from abuse by anyone.

PLEASE NOTE: This non-compliance was issued as a result of Critical Incident Inspection #005178-17 that was conducted concurrently with the RQI Inspection. [s. 19. (1)]

(508)

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

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

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. 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;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(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).

Order / Ordre :

The licensee shall do the following:

1) Develop and implement procedures for daily monitoring of the functioning of the home's resident-staff communication and response system on the third floor to ensure that system clearly indicated when activated where the signal was coming from.
2) Repair all bathroom pull stations on the third floor that are in need of repair so that they do not prevent bed stations in the adjoining rooms from triggering the resident-staff communication and response system.
3) Provide documentation for the monitoring and repairs completed.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is a pattern (2), the severity of the non-compliance has minimum harm or potential for actual harm (2) and the history of non-compliance under Long-Term Care Homes Act, 2007, r. 17(1) is ongoing (3) with one or more related non-

compliance previously issued as a voluntary plan of correction action (VPC) on February 18, 2015.

The home's resident-staff communication and response system, also known as the call bell system, consisted of pull stations that, when activated, triggered a light that illuminated in the hallway above the door of the room where a station was activated, a sound in the hallway and nursing station, and a panel display at the nursing station.

During resident observations between April 26 and 28, 2017, Long Term Care Homes (LTC) Inspector #526 observed that when 12 of 13 bed stations were activated, the light was illuminated but no sound could be heard in 12 identified rooms. In addition, on May 3, 2017, the same bed stations failed to sound when activated, and the lights above the doors of identified rooms did not illuminate in two identified rooms. During these observations, PSWs #259, #106, #108, and #156 confirmed that sound could not be heard when the resident-staff communication and response system was activated and that they may not know that the system had been activated, or where a signal was coming from.

On an identified date, resident #020 was laying in their bed and asked LTC Inspector #526 to assist them to use the bathroom. The resident activated the resident-staff communication and response system by pulling the cord at their bed station; a light was illuminated in the hallway above their door but no sound could be heard. The LTC Inspector observed staff walk past the room as follows: housekeeper #224, the Assistant Director of Nursing (ADOC), housekeeper #224 during a duration of nine minutes after the call bell had been activated. Eleven minutes later, RPN #325 knocked on the door and asked resident #020 why they had not gotten up, closed the door and the light above the door turned off. During interview, RPN #325 stated that they did not hear the call bell sound but saw the light when they went to attend to another resident in that same hallway; they were not aware of how long the resident had been waiting. During interview, housekeeper #224 stated that they would normally assist a resident if they saw a call bell triggered, but that they were not aware that resident #020 had activated their call bell. The ADOC stated that they were not aware that resident #020 had triggered their call bell, even though they were standing outside of the resident's room.

The LTC Inspector reported to the Administrator on April 28, 2017 that the bed station call bells were not triggering a sound. During interview on May 3, 2017,

the Environmental Services Manager (ESM) stated that the system should have a sound. They stated that a new surveillance monitoring system had been installed within the past three weeks that may have disrupted the resident-staff communication and response system on the third floor. They stated that staff would notify maintenance staff using the maintenance book, regarding call bells that were not functioning. The maintenance book was reviewed daily and repair of identified issues would be initiated. They reported that on an identified date resident #020's bed and bathroom stations had been identified as not functioning, were serviced and thought to be functioning. The ESM was not aware of a wide spread sound outage on the third floor that had been identified during this inspection. According to the Administrator, on May 2, 2017, PSW #321 reported to the home's Administrator, ESM and LTC Inspector #526 that if the bathroom stations were not fully cancelled, the bed stations would not activate a sound as they normally should. According to the Administrator, after PSW #253 fully cancelled all bathroom stations, all but two bed stations triggered a sound that could be heard so that staff would know where the signal was coming from. According to the Administrator, as of May 4, 2017, all bed and bathroom stations were functioning so that staff would be aware of where the signal was coming from.

During interview, the ESM confirmed that when bed stations did not trigger a sound, staff may not know that the system was activated or where the resident-staff communication and response system signal was coming from. [s. 17. (1) (f)]

(526)

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. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Order / Ordre :

The licensee shall reassign the laundry duties that are currently assigned to Personal Support Workers or any staff paid from the Nursing and Personal Care (NPC) envelope.

Grounds / Motifs :

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the non-compliance is widespread (3), the severity of the non-compliance has minimal harm (1) and the history of non-compliance under Long-Term Care Homes Act, 2007, s. 101(4) is one or more related noncompliance within the past three years (3) with a written notification previously issued February 18, 2015.

The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care home Service accountability agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in Applicable policy".

The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care".

On May 3, 2017, nursing staff #250 was observed completing laundry duties (delivering personal laundry to resident rooms). Staff #250 verified that delivering personal laundry was a regularly assigned duty.

The Administrator also confirmed on May 3, 2017, that Personal Support Workers (PSW) are assigned the duty of laundry delivery. (508)

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 9th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

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