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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 27, 2017;	2017_509617_0017 (A3)	005392-17, 005872-17, 008322-17, 008329-17, 009350-17, 009450-17, 009475-17, 010165-17, 010285-17, 011409-17, 012578-17, 013222-17, 013754-17, 014266-17, 014321-17, 014579-17, 014625-17, 015338-17, 016185-17, 016793-17, 017522-17, 018064-17, 018284-17, 019633-17, 020917-17	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

Ontario

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RYAN GOODMURPHY (638) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #004, #005 and #006, compliance due date extended until February 28, 2018.

Issued on this 27 day of December 2017 (A3)

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

Original report signed by the inspector.

Ontario

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

RYAN GOODMURPHY (638) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 14-18; August 21-25; and August 28-September 1, 2017

This Critical Incident (CI) System Inspection was conducted as a result of the following 25 critical incident CI reports, the home submitted to the Director, in which

-five were related to staff to resident abuse,

-seven were related to resident to resident abuse,

-nine were related to resident falls resulting in injury,

-two were related to an incident that resulted in resident injury in which they required hospitalization and resulted in a significant change to their health status,

-one was related to an enteric outbreak, and

-one was related to resident elopement.

A Follow Up Inspection #2017_509617_0019, and Complaint Inspection #2017_509617_0018, were conducted concurrently with this Critical Incident System Inspection. Non-compliance pursuant to LTCHA, 2007, S.O. 2007, c.8, s.

6 (1) c and s. 6 (7), identified from this CIS inspection will be issued in concurrent Complaint inspection #2017_509617_0018.

The inspectors conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personnel records, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with the Vice President of People, Mission, and Values (VP), Director of Care (DOC), Clinical Managers (CMs), the Interim Maintenance Manager, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinators (RAI Coord), Physiotherapists (PTs), a Physiotherapy Aid (PTA), Registered Dietitians (RDs), a Security Guard, family members and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Safe and Secure Home

Training and Orientation

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

17 WN(s)
7 VPC(s)
7 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #006 that set out, the planned care for resident #006 and resident #005 regarding fall prevention interventions.

The home submitted a Critical Incident (CI) report whereby resident #006 fell and was taken to hospital resulting in a significant change in the resident's health status. The CI report indicated that resident #006 had an unwitnessed fall in their bedroom and then two days later was assessed by PT #129 to have pain from their fall. Once informed of the resident's pain the physician ordered an x-ray which, confirmed that resident #006 had a fracture.

A review of resident #006's Resident Assessment Minimal Data Set (RAI MDS) by Inspector #617, indicated that the resident required a specific level of assistance from staff, and required the use of a mechanical lift for transfers. A review of resident #006's care plan specifically related to falls indicated that the resident was assessed as a high risk for falling, and required specific fall prevention interventions. A review of resident #006's health care records indicated that since their fall addressed in the aforementioned CI report, they had five subsequent falls where significant injuries were sustained.

On August 30, 2017, Inspector #617 observed resident #006 without two specific fall prevention interventions initiated, as advised in the plan of care. Again, on the same day, Inspector #617 observed resident #006's room and identified that numerous fall prevention interventions were not initiated.

On August 30, 2017, the Inspector interviewed PSW #133 who reported that resident #006 had many falls as they were known to self-transfer and did not have the ability transfer safely. PSW #133 further reported that there were a number of fall prevention interventions provided by staff to prevent the resident from falling.

A review of resident #006's post fall assessments related to the five falls that occurred after the critical incident, a total of nine fall prevention interventions had not been initiated as indicated in the plan of care.

On August 30, 2017, in an interview with RPN #130, they reported to the Inspector that after each resident fall, the registered staff were expected to complete a post fall assessment, collaborate with the team to determine what had happened during the fall, review the post fall assessment data and update the care plan accordingly.

During the interview with the Inspector, PSW #133 described five individual fall prevention interventions within the resident's written plan of care.

In an interview with Clinical Manager (CM) #135, they reported that the information determined from the resident's post fall assessment was to be reviewed by the team and updated in their written care plan. CM #135 then confirmed that the information determined by the post fall assessments completed for resident #006's five falls, and the nursing interventions currently provided should have been updated in their care plan. [s. 6. (1) (a)]

2. RN #137 had submitted a CI report to the Director for resident #005's unwitnessed fall from their bed. As a result of the fall, the CI report identified that the resident sustained a fracture.

Inspector #616 reviewed the resident's care plans related to falls prevention in effect prior to the incident as well as the most current care plan. In both care plans the resident was identified at high risk for falls.

The Inspector reviewed progress notes and the post-fall assessment documented

after the resident's fall by RPN #121, and the "shift to shift" reports where it was identified how resident #005's fall occurred.

On August 24 and 25, 2017, respectively, PSWs #158 and #159 both reported separately to Inspector #616 that they were aware of resident #005's high fall risk. PSW #158 described an intervention they had implemented to keep the resident safe. Both PSW #158 and PSW #159 stated that resident #005's care plan did not clearly identify the intervention they implemented as a falls prevention intervention. RPN #121 also stated that the intervention that PSW #158 used was effective as mitigating a risk of falling for the resident and confirmed the described intervention was not in place at the time of the incident.

On August 24, 2017, during an interview with RN #137, they confirmed to the Inspector that the omission of the described intervention did not clearly identify the planned care for resident #005. [s. 6. (1) (a)]

3. The licensee has failed to ensure that there was a written plan of care for resident #001 and resident #017 that set out, clear directions to staff and others who provide direct care to the resident regarding responsive behaviours.

A CI report was submitted to the Director by RN #137 (Interim Manager), for a resident to resident physical altercation. In the CI report, resident #001 sustained an injury after being struck by resident #002. The CI report had identified that both residents were known to demonstrate, "behaviours".

Inspector #616 reviewed the care plans (and associated Kardex) in effect at the time of the altercation for both resident #001 and resident #002. The "Behaviour Problem" focus for resident both resident #001 and resident #002 directed staff to identify residents using a chart number. The care plan indicated that both residents had verbally aggressive behaviours and interventions instructed staff to minimize residents' #001 and #002's interactions with three other residents on the unit including each other. These residents were identified by different chart numbers.

During an interview with PSW #160, they stated to the Inspector that they were aware of resident #001's actions towards co-residents, which triggered a response by certain residents with the potential for altercations, as well as interventions to prevent them. RPN #161 was also interviewed by the Inspector and described additional actions by resident #001 towards co-residents. They also identified strategies to minimize altercations. However, after a review of the Behaviour

Problem Kardex for both resident #001 and #002, PSW #160 and RPN #161 each stated that the identified chart numbers associated with the residents did not provide staff with clear direction as to which residents were being monitored or redirected. The RPN stated they would have to look up the chart numbers in the computer to identify the residents.

During the Inspector's interview with Interim Manager RN #137, they stated that resident identification by chart number did not provide staff with clear direction as it would be very difficult and time consuming for staff to review each chart, particularly when implementing interventions to minimize resident to resident altercations. [s. 6. (1) (c)]

4. Inspector #613 reviewed a CI report that was submitted to the Director which identified physical abuse between resident #017 and #018. The CI report revealed that resident #017 has sustained an injury after being struck by resident #018.

A review of the progress notes identified an intervention implemented for resident #017 as a deterrent to prevent recurrence by resident #018. A review of resident #017's care plan revealed the intervention identified in the progress notes. There was no further direction as to when to apply or remove the intervention.

The Inspector observed resident #017 at different periods of time throughout the day and evening shifts and did not observe the intervention applied.

During an interview with PSW #110, they informed the Inspector that resident #017 removed the intervention during the day and reapplied it at night. PSW #110 confirmed that the care plan did not identify this information and did not provide clear direction for the use of the intervention.

During an interview with RN #111, they stated that resident #017 did not require the intervention any longer and that it had been removed as they had only one incident and nothing further. RN #111 confirmed the care plan had not been updated to reflect this.

During an interview with resident #017, the Inspector observed the intervention lying on the floor in the resident's room. Resident #017 described the reason for the intervention. Resident #017 informed the Inspector that they removed the intervention during the day and it was applied night. The resident confirmed this was their preference for the use of the intervention. [s. 6. (1) (c)]

5.The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The home submitted a CI report related to an incident that caused an injury to resident #008 for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CI report indicated that resident #008 complained of pain after an activity. Resident #008 was complaining of pain, treated with analgesia and the resident's family member took them to the hospital where they were diagnosed and treated for an injury.

A review of resident #008’s health care record (HCR) indicated that PT #117, assessed the resident’s transfer status and determined that they were no longer able to safely perform certain movements. PT #117’s assessment indicated that the resident was to be transferred using a specific transfer device.

In an interview with PT #117, they confirmed to the Inspector that they assessed the resident to have a specific transfer device for all transfers due to their inability to perform certain movements.

A review of resident #008’s care plan relevant to the time of the PT #117’s assessment for transfer status, indicated that the resident required to be transferred with a specific transfer device.

A review of resident #008’s HCR over the period of 18 days, when resident #008 started to complain of pain, to the time when they were diagnosed with an injury, indicated that, registered staff referred the resident to physiotherapy. The Physiotherapy assessment completed by PT #129 indicated that resident #008’s transfer status was assessed to require a certain level of assistance and therapy treatment to the area of injury was prescribed. A review of the physiotherapy aid treatment documentation indicated that resident #008 received therapy treatment to the area of injury, one day before the resident was diagnosed with the injury.

During the interview with PT #117 they reviewed resident #008’s transfer status assessed by PT #129 with the Inspector and confirmed that this assessment was incorrect and should have indicated that the resident’s transfer status required a specific transfer device due to their inability to perform certain physical movements.

PT #117 further explained that resident #008's plan of care was integrated to the use of the specific transfer device, and PT #129's assessment was not consistent with PT #117's assessment.

During the interview with PT #117, they confirmed to the Inspector that resident #008 received therapy treatment to their area of injury. PT #117 explained that resident #008's injury could only be diagnosed with x-ray and that the therapy that was assessed and provided to the resident was not consistent with the resident's diagnosed injury. [s. 6. (4) (a)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that there is a written plan of care for resident #001 and resident #017 that sets out, clear directions to staff and others who provide direct care to the resident regarding responsive behaviours, and

-to ensure that the staff and others involved in the different aspects of care of resident #008 and all other residents collaborate with each other, in the assessment of the resident so that their assessments are integrated and consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 :

(A1)
1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

1) Pursuant to the LTCHA, 2007, s 20 (1), the home had failed to ensure on two separate occasions that their written policy to promote zero tolerance of abuse and neglect of residents was complied with specific to their procedure for reporting allegations of abuse.

a) The home submitted a Critical Incident (CI) report regarding an incident of alleged staff to resident abuse. The CI report indicated that an email from PSW #146 was received by the home regarding seven allegations of abuse to residents by PSW staff including alleged physical, emotional and verbal abuse.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect- #LTC 5-51", dated February 2016, indicated that all employees and affiliated personnel were required to fulfill their moral and/or legal obligation to report an incident of resident abuse to their manager/designate. Any employee or board member who was aware of or suspects abuse of a resident by anyone, or neglect of a resident by an employee, must report it as soon as possible in accordance with the reporting procedures.

A review of the home's investigation notes indicated that VP #145, had been sent an email describing the concerns of alleged staff to resident abuse on a specific date, and VP #145 had acknowledged receipt of the email three days later.

In an interview with VP #145 they confirmed to the Inspector that the allegations reported by PSW #146 were incidents of physical and emotional abuse that were required to be reported to the registered staff or Clinical Manager for immediate reporting to the Director. VP #145 further confirmed to the Inspector that PSW

#146 did not follow the home's policy in reporting the allegations of abuse which resulted in late reporting to the Director.

b) The home submitted a CI report regarding staff to resident verbal abuse. The CI report indicated that PSW #149 and PSW #150 reported to CM #152 that agency PSW #151 had acted disrespectfully and used profanity towards resident #014 while providing care. The incident occurred on a specific date, and was not reported to the CM #152 until one day later.

Inspector #617 interviewed the DOC who confirmed to the Inspector that the CI report of verbal and emotional abuse of resident #014 by agency PSW #151 was a mandatory report that was required to be reported immediately by PSW #149 and PSW #150 to their CM #152. The DOC further confirmed to the Inspector that both PSW #149 and PSW #150 did not follow the home's policy on mandatory reporting resulting in late reporting to the Director.

Non-compliance related to s. 20 (1), of the LTCHA, 2007, is being issued in WN #14.

2) Pursuant to the LTCHA, 2007, s. 23 (1), the licensee failed on three occasions to ensure that appropriate action was taken to every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee.

a) On the first occasion, the home submitted a Critical Incident (CI) report regarding an incident of alleged staff to resident abuse. The CI was reported on a specific date, to the Ministry of Health and Long Term Care (MOHLTC) After Hours pager, by the DOC. The CI report was submitted to the Director nine days after it occurred, and indicated that the home received the allegation from a staff member 15 days before the report to the Director was submitted, that seven allegations of abuse to residents by PSW staff had occurred. Please refer to WN #2, finding #1a, for further details, pertinent to the CI report.

In an interview with the DOC, they clarified to the Inspector that the initial report by the staff member did not identify the names of residents or staff members involved. The home conducted their preliminary investigation and determined that PSW #148 was implicated in the allegations of abuse toward two residents.

A review of the home's investigation indicated that 16 days after receiving the

allegation, the home concluded, PSW #148's actions towards residents #010 and #038 on three out of the seven allegations, were found to be abusive.

In conclusion the home had conducted their investigation over a period of 11 days after becoming aware of the allegation. A review of the staffing schedules and interviews with the DOC confirmed that the home failed to protect resident #010 and resident #038 from having contact with PSW #148, during the time of the investigation, and did not remove the PSW from working on the resident's respective units for five occasions, placing both residents at risk.

b) On the second occasion, the home submitted to the Director a Critical Incident (CI) report regarding incompetent/improper treatment of a resident by a PSW. The incident was reported to the MOH LTC After Hours pager on a particular day. The CI report indicated that resident #015 disclosed to a family member, that a PSW was verbally abusive to them, and that resident #015 was afraid of reporting this incident as they would "not get the care they needed". The CI report indicated that resident #015's family member had reported this incident to the home and the time the incident had occurred and the identification of the PSW was unknown.

A review of the home's investigation by Inspector #617, identified that PSW #154 was implicated in the incident and there was no indication of a conclusion to the investigation of incompetent treatment of resident #015.

In an interview with both the DOC and RN #137, they reported to the Inspector that during the time that this incident had occurred, RN #137 was the interim CM of the unit where resident #015 was residing and PSW #154 was working. They clarified to the Inspector that the home was made aware of the incident on on the particular day (when reported to the MOHLTC), and had completed their investigation five days later when it was concluded that the allegation of incompetent treatment was not founded.

Both the Inspector and DOC reviewed the home's policy "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21" and the DOC confirmed to the Inspector that PSW #154 who was implicated with an allegation of incompetent treatment of resident #015 was not removed from work, and the home did not protect the resident during the time of the investigation.

c) On the third occasion, the home submitted to the Director a CI report regarding staff to resident verbal abuse. The CI report indicated that a staff member was

overheard by a co-resident speaking to resident #031 in a "not normal" tone. The staff member was heard to have aggressively and repetitively requested the resident to perform a specific action. The CI report indicated that the incident occurred on a certain day, and was submitted one week later.

A review of the home's investigation notes by Inspector #617, indicated that resident #031's Substitute Family Member (SDM) reported the incident to the CM #138 two days after the incident occurred, which identified the implicated staff member as RPN #113. The investigation did not indicate a conclusion to the home's investigation of verbal abuse to resident #031.

Both the Inspector and CM #138 reviewed the home's policy titled, "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21", and the CM confirmed to the Inspector that the policy of the home was to remove RPN #113 who was alleged to have provided incompetent treatment to resident #015, from work, to protect the resident during the time of the investigation. CM #113 further confirmed that resident #031 was not protected from further contact with the implicated staff member.

Non-compliance related to s. 23 (1) (b), of the LTCHA, 2007, is being issued in WN #15.

3) Pursuant to LTCHA, 2007, s. 23 (2), the licensee had failed to ensure that the results of the abuse or neglect investigation were reported to the Director on two separate occasions.

a) On the first occasion, Inspector #613 reviewed a CI report that was submitted to the Director on a specific date, which identified physical abuse between resident #017 and #018 that resulted in an injury to resident #017.

b) On the second occasion, Inspector #613 reviewed a CI report that was submitted to the Director on another particular date, which identified physical abuse between resident #022 and #019, which resulted in resident #022 sustaining an injury.

During an interview on August 16, 2017, with the Director of Care, they confirmed to the Inspector that both CI reports had not been updated with the outcome of the investigation and reported to the Director.

Non-compliance related to s. 23 (2), of the LTCHA, 2007, is being issued in WN #15.

4) Pursuant to the LTCHA, 2007, s 24 (1), the licensee had failed to ensure that on five occasions, the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

a) On the first occasion, Inspector #613 reviewed a CI report submitted to the Director on a specific date, identifying physical abuse with injury. The CI report described an injury to resident #020 which was caused by resident #019.

During an interview on August 16, 2017, with the DOC, they indicated that the RN was in charge of the unit and was expected to notify the MOHLTC After Hours pager as well as the Manager on call, the day of which the incident occurred. The DOC confirmed that the Director was not immediately notified by the RN of this incident until one day later when it was reported late to the Director.

b) On the second occasion, Inspector #613 reviewed a CI report submitted to the Director on a specific date, identifying physical abuse with injury to resident #023.

During an interview on August 16, 2017, with the Director of Care, they indicated that the RN was expected to notify the Director using the MOHLTC After Hours pager, as well as the Manager on call, on the day the incident occurred. The DOC confirmed that the Director was not immediately notified by the RN of this incident two days later when the incident was reported late to the Director.

c) On the third occasion, the home submitted a CI report regarding incidents of alleged staff to resident abuse. The CI report was submitted on a particular date, to the MOHLTC After Hours pager by the DOC. The CI report was submitted to the Director nine days later, and indicated that an email from PSW #146 was received six days prior to the initial report to the MOHLTC, regarding seven allegations of abuse to residents by PSW staff. Please refer to WN #2 for further details.

In an interview with VP #145 they confirmed to the Inspector that the allegations reported by PSW #146 were incidents of physical and emotional abuse that were required to be reported immediately to the Director. VP #145 further clarified that they were aware of the allegation of resident abuse the day when they

acknowledged receiving the email from PSW #146, and were required to immediately report the suspicion to the Director but did not, which resulted in late reporting.

d) On the fourth occasion, the home submitted to the Director a CI report regarding staff to resident verbal abuse. The CI report indicated that a staff member was overheard by a co-resident speaking to resident #031 in a "not normal" tone. The staff member was heard to have aggressively and repetitively requested the resident to perform a certain activity. The CI report indicated that the incident occurred on a specific date, seven days before the CI report was submitted to the Director.

In an interview with the DOC they confirmed to the Inspector that the critical incident involving the allegation of RPN #113 verbally abusing resident #031 was a mandatory report, required to be reported immediately to the Director on the date it occurred, by CM #138, and that it was reported late.

e) On the fifth occasion, resident #040's family member reported to Inspector #617 that on August 20, 2017, resident #037 exhibited physically responsive behaviours resulting in injury to resident #040.

Inspector #617 reviewed resident #037's progress notes which confirmed that on a specific date, a physical altercation had occurred between residents #037 and #040 resulting in injury to resident #040.

On August 25, 2017, Inspector #617 interviewed the DOC, who reviewed resident #037's progress note, and confirmed that the incident where both residents #037 and #040 had a physical altercation resulting in injury to resident #040, was required to be immediately reported to the Director, and was not yet reported.

During the inspection, the home submitted a Critical Incident report to the Director regarding resident to resident physical abuse. The CI report indicated that on the specified date, RPN #130, witnessed a physical altercation between resident #037 and resident #040. RPN #130 then separated the residents and discovered an injury to resident #040. The CI report was submitted on a particular number of days after the critical incident had occurred.

In an interview with CM #138, they confirmed to the Inspector they were aware the day after the incident, of the incident that occurred on the specific day, after

reading the safety report submitted by RPN #130. CM #130 further explained that at that time, they did not recognize resident #040's injury as a form of abuse, they discussed the incident at the manager's meeting and they were not given direction to report the incident, that day. CM #138 confirmed to the Inspector that as a result, the notification to the Director was late.

Noncompliance related to s. 24 (1), of the LTCHA, 2007, is being issued in WN #16.

5) Pursuant to O. Reg 79/10, s 104. (2), the licensee had failed to ensure that subject to subsection (3), the licensee submitted the written report within 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse of a resident by anyone, or at an earlier date if required by the Director.

The home submitted to the Director a CI report regarding incompetent/improper treatment of a resident that resulted in risk of harm to a resident. The incident was reported to the MOHLTC After Hours pager initially on a particular day, and the home then submitted the written report to the Director 26 days later.

In an interview with the DOC they confirmed to the Inspector that they had submitted the CI written report to the Director 26 days after the initial report to the MOHLTC, as submitting the written CI report for this incident had "fallen through the cracks." The DOC further explained that RN #137 was the Interim Manager of the unit at the time that the incident was reported and the investigation was conducted, and that RN #137 did not have access to the CI reporting online site.

Noncompliance related to s. 104. (2), of the Regulation, is being issued in WN #17.

6) Pursuant to the LTCHA, 2007, s. 76 (2), the licensee has failed to ensure that all staff at the home have received orientation training including but not limited to the home's policy to promote zero tolerance of abuse and duty to report as issued under WN #7, Compliance Order #007.

7) In interviews with the Inspector, newly hired CM #138 reported to the Inspector that their lack of experience with recognizing incidents that required them to take immediate action and report to the Director resulted in non-compliance. During an interview with the DOC they confirmed to the Inspector that during the time RN #137 was acting as Interim Manager, they did not have access to the Critical Incident System online reporting system, to report a critical incident referred in WN

#16 of this report.

In interviews with the DOC they reported that the home has had management turnover over the last six months including the Administrator, DOC and CM positions.

In conclusion the licensee failed to protect residents from abuse and neglect by failure to: report, adhere to the home's zero tolerance of abuse policy, respond with appropriate actions to alleged, suspected or witnessed abuse and complete required orientation training.

DR#001 The above written notification is also being referred to the Director for further action by the Director. [s. 19. (1)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were kept closed and locked.

Inspector #620 reviewed a CI report that was submitted to the Director, which described that on a particular day, both resident #026 and #025 were determined by staff to be missing from the home. The CI report described that resident #026 was capable of leaving the home; however, resident #025 was not capable; and as a result, resident #025 had interventions in place to prevent the resident from exiting the facility. The home determined that resident #025 left the home in the care of resident #026 but that while off site, resident #026 left resident #025 on their own. Resident #025 was found a distance away from the home and was returned unharmed. Resident #026 returned to the home on their own.

Inspector #620 interviewed the home's Security Guard who indicated that they recalled the incident when resident #025 and #026 went missing. They indicated that following the incident, they were advised that resident #026 was no longer

allowed to leave the facility with resident #025. They indicated that following the incident resident #026 had tried to leave the facility with resident #025 through a particular exit in the home. The Security Guard indicated that this exit was the only door in the facility that would not lock when a resident with a particular intervention in place was in close proximity to the door. Therefore, resident #025 could be assisted by resident #026 to exit the home via the particular exit.

Inspector #620 tested the particular exit door, utilizing the particular intervention, and the Inspector was able to exit this particular door.

Inspector #620 observed that on August 16, 2017, at 0917 hours, the particular door was under repair by a contractor. At the time of the observation the door was observed to propped open. The door was left ajar from 0917 hours, to 1400 hours. The Inspector observed that the doorway was not being monitored by any staff member.

On August 16, 2017, Inspector #620 interviewed the home's Security Guard about the particular door being propped open. They indicated that while the door had been propped open, resident #030 had exited through this door. They indicated that resident #030 utilized the particular intervention and that they frequently tried to exit the home. They indicated that resident #030 returned to the home without incident.

Inspector #620 interviewed the home's DOC #140 who indicated that the home's particular door should not have been left open and unlocked. They indicated that it was expected that when repairs were being made to an exit door that maintenance staff were to remain onsite to secure the door. [s. 9. (1) 1. i.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CI report to the Director for an incident that caused an injury to resident #003. In the CI report, PSW #116 transferred resident #003 using a specific mechanical lift when the resident slipped through the sling and onto the floor. The resident was transferred to hospital, diagnosed with a fracture, and returned to the home.

Inspector #616 reviewed the home's investigation record that verified that resident #003 had sustained an injury as a result of PSW #116 performing a one person transfer using this specific mechanical lift when two staff were required during this transfer.

The Inspector reviewed the resident's transferring care plan which identified that resident #003 required a specific mechanical lift.

The Inspector reviewed the home's "Guidelines for Minimal Lift", undated, that referenced policy HR 7-223, where the "Mechanical Lifts" or mobile lifting devices, required two caregivers to operate.

During the Inspector's interviews with PT #117 and PSW #118 separately, they verified that any mechanical lifts, including the resident's specific mechanical lift required two staff, one to operate the lift, the other to monitor the resident. The PT confirmed to the Inspector the resident's care plan indicated that the resident required one person for assistance which was an unsafe practice using the specific mechanical lift.

During an interview with the DOC, they confirmed that resident #003's care plan that indicated the resident transferred by one staff using the specific mechanical lift was unsafe. [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents #004, #006 and #007 had fallen, the residents were assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted a CI report whereby resident #007 had fallen causing an injury and was taken to hospital resulting in a significant change in their health status. The CI report indicated that resident #007 was found on the floor after attempting to self-transfer. The CI report also identified that both RN #132 and RN #164 assessed the resident and that they suspected an injury. Resident #007 was sent to the hospital and they were diagnosed with a fracture.

A review of resident #007's post fall assessments indicated that an assessment was missing for the fall that had occurred.

In an interview with RAI Coord #131, on August 31, 2017, they confirmed to the

Inspector that a post fall assessment was missing for the resident’s fall.

A review of the home's policy titled, "Fall Prevention and Management Program - LTC 3-60", dated April 2014, indicated that registered staff were required to lead the team in completing the post fall assessment following each resident fall. The post fall assessment included the "Post Fall Screen for Resident/Environmental Factors" and the "Falls Assessment".

On August 31, 2017, in an interview with RPN #139, they reported to the Inspector that after each resident fall, the registered staff were expected to complete a post fall screen for resident/environmental factors assessment and a fall risk assessment on the electronic documentation system, Medecare. The registered staff were then expected to collaborate with the team to determine what had happened during the fall, review the post fall assessment data and update the care plan accordingly.

In an interview with CM #138, who reviewed the home's policy related to falls prevention with the Inspector and confirmed to the Inspector that registered staff were expected to have completed a post fall assessment for resident #007. CM #138 further confirmed that at the time of their fall resident #007 was to have interventions in place to prevent their falls and that the post fall assessment was required to be completed to determine the cause of the fall and to make changes to the care plan when necessary. [s. 49. (2)]

2. The home submitted a CI report to the Director whereby resident #006 had fallen and was taken to hospital resulting in a significant change in the resident's health status. The CI report indicated that resident #006 had an unwitnessed fall and then two days later were assessed by PT #129 to have pain as a result of their fall. Once informed of the resident’s pain, the physician ordered an x-ray which, confirmed that resident #006 had sustained a fracture.

A review of resident #006’s post fall assessments indicated that an assessment was missing for their fall that had occurred.

In an interview with RAI Coord #131, on August 30, 2017, they reviewed resident #006's post fall assessments and confirmed that their post fall assessment was missing.

On August 31, 2017, in an Interview with RPN #130, they reported to the Inspector

that after each resident fall, the registered staff were expected to complete a post fall screen for resident/environmental factors assessment and a fall risk assessment on the electronic documentation system, Medecare. The registered staff were then expected to collaborate with the team to determine what had happened at the fall, review the post fall assessment data and update the care plan accordingly.

Inspector #617 interviewed the DOC, on August 30, 2017, who confirmed that resident #006 fell and were later discovered to have sustained a fracture; the registered staff should have completed a post falls assessment. [s. 49. (2)]

3. A CI report was received by the Director concerning resident #004's fall and resulting fracture.

Inspector #577 conducted a record review of resident #004's progress notes, which indicated that the resident had an unwitnessed fall, had complained of pain, and were transferred to an acute care facility for an assessment.

On August 25, 2017, the Inspector reviewed the home's policy titled "Falls Prevention - #CL 1-29" last revised December 1, 2016, which indicated that a falls risk assessment and a post falls risk assessment were to be completed after a fall. A review of the home's "Falls Prevention and Management Toolkit" last revised April 2017, indicated that registered staff were to complete a post fall screen for environmental factors after a fall.

Inspector #577 conducted a record review of resident #004's health care records and could not find a post-fall screening assessment completed after the resident's fall.

During an interview with RN #137 on August 25, 2017, they reported that a post fall screen for environmental factors was not completed for the fall.

During an interview with RAI Coord #131, they confirmed that resident #004 did not receive a falls assessment, a falls risk assessment or a post fall screen for environmental factors after their fall.

During an interview with the DOC on August 25, 2017, they confirmed that a post fall screen assessment had not been completed after resident #004's fall. [s. 49. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 58. Every licensee of a long-term care home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion. O. Reg. 79/10, s. 58.

Findings/Faits saillants :

1. The licensee failed to ensure that when transferring resident #008, staff used devices and techniques that maintained or improved, wherever possible, the resident's weight bearing capability, endurance and range of motion.

The home submitted a CI report related to an incident that caused an injury to resident #008 for which the resident was taken to hospital which resulted in a significant change in the resident's health status. The CI report indicated that resident #008 complained of pain after an activity. Resident #008 was complaining of pain, and was treated with analgesia. The resident's family member took them to the hospital where they were diagnosed and treated for an injury.

On August 28, 2017, in an interview with resident #008 they explained to Inspector #617 how they had fallen while being assisted by a PSW, and were injured as a result. Resident #008 further explained that at the time of the fall, they were

required to use a a specific device for transferring. Resident #008 reported that they couldn't remember the date of the fall.

A review of resident #008's progress notes, post fall assessments and safety incident report indicated that two weeks prior to the CI report submitted to the Director, the resident fell while being assisted with an inappropriate transfer. At the time of the fall resident #008's transfer status had been changed to use a specific device for transferring and the PSW did not use this device for the transfer.

The CI report and the interview with resident #008 identified that staff did not use the appropriate device to transfer the resident on two separate occasions.

On August 29, 2017, in an interview with PSW #141 they confirmed to the Inspector that at the time of the incident they transferred resident #008 by using an incorrect technique which resulted in the resident falling to the floor. PSW #141 further confirmed to the Inspector that they did not use a specific device during the transfer. PSW #141 explained that at the time of the transfer they were not aware that the resident's care plan had changed.

A review of resident #008's health care record indicated that on a particular date PT #117, assessed the resident's transfer status and determined that the resident was to be transferred using a specific device.

On August 29, 2017, in an interview with PT #117, they confirmed to the Inspector that they assessed the resident and determined that the resident needed to use a specific device for all transfers. PT #117 explained to the Inspector that at the time of the assessment they informed the registered staff that they needed to update the resident's care plan interventions to instruct the staff to use the specific device with all transfers and change the transfer logo at the resident's beside.

On August 29, 2017, in an interview with RPN #142, they confirmed to the Inspector that they had changed resident #008's care plan and logo at their bedside to indicate that for all transfers they were to use the specific device. RPN #142 reported to the Inspector that they attended to resident #008's fall in which PSW #141 incorrectly provided the resident with a transfer.

In an interview with RN #143, they confirmed that they had assessed resident #008's pain when the critical incident occurred. RN #143 confirmed to the Inspector that at the time of the incident, the resident was required to use a specific device

for transferring and that the staff did not use the device when they assisted the resident to transfer. RN #143 clarified that all transfers according to the PT assessment required the use of the specific device.

In an interview with CM #138, they confirmed to the Inspector that when the PT assessment indicated the use of a specific device for transfers, they expected the staff to transfer resident #008 using the specific device on both occasions when they fell. [s. 58.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 006

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that all staff have received training in the home's policy to promoted Zero Tolerance of Abuse and Neglect of residents before performing their responsibilities.

On September 6, 2017, in an interview with the DOC they informed the Inspector that VP #163, had been hired on a specific date, as the VP of Senior Health Services and then on a later date assumed the acting Administrator role for the home.

A review of VP #163's "Education Master" file dated two months after their initial hire date, did not indicate that they were trained in the home's policy for Zero Tolerance of Abuse.

In an email dated September 6, 2017, from the DOC to the Inspector, the DOC clarified that VP #163 had not been trained in the home's Zero Tolerance of Abuse Policy and was scheduled for their training.

During the time when VP #163 was acting Administrator till the date they were scheduled for their training, they had not been trained in the home's policy for Zero Tolerance of Abuse. [s. 76. (2)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 007

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place a falls prevention and management program, the licensee was required to ensure that the program was complied with.

A CI report was submitted to the Director for resident #005's unwitnessed fall.

Inspector #616 reviewed the home's policy titled "Falls Prevention (Corporate) - #CL 1-29", dated December 1, 2016, that referenced St. Joseph's Care Group Falls Prevention and Management Toolkit-Draft, dated April 2017. In the toolkit, when a resident had fallen, the registered staff were to initiate the Head Injury Routine (HIR) protocol for all falls including unwitnessed falls. Registered staff were to monitor the resident for signs of neurological changes every hour for the first four hours and then every four hours for 24 hours post fall. In addition, the registered staff were to emphasize the details of the fall, interventions and outcomes and stress the need for ongoing follow-up in subsequent shifts during the shift to shift report.

The Inspector reviewed resident #005's health care record regarding their unwitnessed fall. The Inspector reviewed a paper form titled "Head Injury Routine" found in the resident's chart. Two assessments had been documented: the first, following the incident when RPN #121 had documented that there was no injury and no complaint of pain; the second was two days later when RPN #121 had documented that the resident had complained of pain.

During the Inspector's interview with RPN #121, they stated that when a resident

had an unwitnessed fall, the HIR protocol was initiated and completed on a paper record that included monitoring every hour for the first four hours, then every four hours for 24 hours after the fall. They verified that the HIR had not been completed as required for this resident.

During the Inspector's interview with RN #137, they stated that they had not followed up with the PSW, nor could they identify who the PSW was. They also confirmed that the PSW had not documented their discovery of finding resident #005 after the fall in the progress notes as they should have. They also confirmed to the Inspector that the HIR protocol had not been completed as required by the home's policy.

During an interview with DOC, they confirmed that the registered staff were required to initiate and complete the HIR protocol for un-witnessed falls as required by the home's policy for falls prevention. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required the licensee to have, institute or otherwise put in place a Falls Prevention and Management program, the licensee is required to ensure that the program is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #620 reviewed a CI report that was submitted to Director. The CI report, detailed staff to resident emotional and physical abuse, and described that RPN #113 had moved resident #016's call bell leaving it out of the resident's reach.

A review of resident #016's Health Care Record (HCR) revealed that they used a call bell that allowed resident #016 to activate the call bell in a specific manner.

Inspector #620 reviewed the home's investigation which revealed that RPN #113 had moved the resident's call bell out of reach of resident #016. RPN #113 described in an interview with a CM #135 that resident #016 was heard trying to call the attention of staff on numerous occasions. They also stated that later in the morning resident #016 was saying, "Call bell Call bell." RPN #113 indicated that they were unaware that the resident's call bell was out of their reach.

The investigation notes indicated that the home had determined from their

investigation that RPN #113 had left the resident out of reach of their call bell for more than 140 minutes.

Inspector #620 interviewed resident #016 who indicated that RPN #113 came into their room and moved their call bell out of reach. They said that they told the RPN that they could not reach the bell, and that the RPN told them that it was within their reach. They indicated that they made numerous attempts to contact a staff member but no one responded.

Inspector #620 interviewed RPN #113 who indicated that they remembered resident #016 attempting to get the attention of staff. They denied hearing the resident ask to put the call bell closer to them. They indicated that they were unsure of how the resident's call bell functioned and they did not realize that the call bell was out of reach of the resident. They confirmed that the call bell had been left out of reach of the resident.

Inspector #620 interviewed DOC #114 who confirmed that as a result of the home's investigation they had determined that the resident did not have their call bell accessible for more than two hours. They stated that all staff were expected to ensure that residents had access to their call bell. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #10: 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. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care plan identified the resident and included, at a minimum, the following with respect to the resident: any risks the resident posed to himself or herself, including any risk of falling, and interventions to mitigate those risks

The home submitted a CI report to the Director related to an injury which resulted in a significant change in resident #003's health condition.

Inspector #616 reviewed the CI report which identified that resident #003 had been transferred and admitted to hospital with a fracture after they had complained of pain and a physical assessment was completed by registered staff. The CI report also identified that the resident had denied a fall. The home had documented that they had no record of falls for resident #003 from their admission; however, the home amended the CI report to include that the resident was known to have had numerous falls prior to admission to the home.

The Inspector reviewed the resident's Health Care Record including the Resident Profile and 24 Hour Care Plan (in use for 21 days post admission), found in the Kardex binder, three days prior to the resident #003's admission. The care plan included that the resident was independent with ambulation and used a specific mobility aid for transferring. In the "Falls" section of the care plan, "history of falls" was selected, however "fall risk"; "date of last fall"; and "previous fractures" were blank.

The Inspector reviewed progress notes in the electronic documentation system, MED e-care and found documentation by RN #100 regarding the resident's admission. The RN had included that the resident ambulated with a specific

mobility aid along with additional diagnosis and symptom related information, but no additional information related to their fall risk was identified.

The home's policy outlined in a draft document titled "Falls Prevention and Management Toolkit", dated April 2017, was provided to the Inspector as the policy currently used by staff. Under the heading "Plan of Care", the registered staff were required to initiate a written plan of care within 24 hours of admission based on the resident's assessed condition, fall history, needs, behaviours, medication and preferences using the Fall Prevention Strategies located in "Appendix B".

During an interview with PSW #102, they verified the 24 hour Care Plan was accessed by staff for the care needs of new residents. The Inspector reviewed the "Falls" section of resident #003's 24 hour Care Plan. The PSW stated that this section should have been "more in depth" as it only identified that the resident had a history of falls. They further stated that the care plan did not identify the level of the resident's risk for falls, when they last had a fall, nor did it give clear direction for staff on "what to do" as there were no interventions for staff to manage the resident's history of falls.

During staff interviews with the Inspector, RN #103 stated that where resident #003's 24 hour Care Plan noted "history of falls", there should have been interventions care planned to address their history of falls. RN #111 verified the 24 hour Care Plan was referred to by the PSWs for the care needs of new residents. RN #111 also stated that this care plan did not provide direction to PSWs related to the resident's fall risk or interventions to mitigate those risks.

During an interview with RAI Coord #104 they verified to the Inspector that the 24 hour Care Plan had been initiated by them in advance of the resident's admission. They stated that it was an expectation that the admitting registered staff reviewed the care plan with the resident and/or family on their admission to the home, to capture any outstanding information not initially captured by RAI Coordinator. The RAI Coordinator also reviewed the 24 hour Care Plan for resident #003, and stated that the resident's risk related to falls was not identified, nor were there interventions identified to mitigate those risks.

During an interview with CM #135, they verified that the 24 hour Care Plan for resident #003 was in effect at the time of diagnosis of their fracture. They stated that the resident's fall risk was not identified as it should have been based on the indicated "history of falls" in the 24 hour Care Plan and interventions for staff

related to falls prevention should have been developed but were not. [s. 24. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care plan identified with respect to the resident includes at a minimum: any risks the resident poses to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

RN #137 had submitted a CI report to the Director for resident #005's unwitnessed fall. In the CI report, RPN #121 had completed the post fall assessment but was unable to determine signs of a fracture. Further, the resident reportedly did not display any signs of pain during the assessment. However, the CI report identified that two days later, RN #164 and RPN #121 had assessed resident #005 and

observed signs of injury, and it was documented that the resident "was in pain". The resident was transferred to hospital and returned to the home having sustained a fracture.

Inspector #616 reviewed progress notes related to resident #005's pain management from the incident with no apparent injury, to their transfer and return from hospital, with fracture. After the initial incident note, the next progress note was documented two days after their fall where there were "no signs of discomfort or injuries noted from". Four hours later, a registered staff member had documented that a PSW had reported signs of injury, and that the resident, "was having some pain".

Throughout the progress notes, the Inspector found that registered staff had assessed the resident's area of injury and documented physical changes to the area including the resident's complaints of pain on three instances over a 22 hour period, at which time the physician ordered different pain medication. On each of those three instances, the registered staff had indicated their plan and/or action to, "monitor" that the "resident [was] on scheduled pain medication", and that a note was to be left for the physician after an unsuccessful attempt to contact them.

The resident's care plan related to pain in effect at the time of their fall identified the goal for the resident to remain comfortable and that staff were to administer medication as ordered and assess effectiveness of medications given.

The Inspector reviewed resident #005's electronic health record for pain assessments. An assessment had been completed prior to their fall, where the resident's pain was identified as discomfort, experienced rarely, and that specific medications were adequate interventions to control the pain.

The Inspector reviewed the resident's medication orders and their Medication Administration Record (MAR) for pain management and found that they were ordered and had received regularly scheduled pain medication. In addition, the resident had an order for as needed (prn) pain medication tablet every four hours when necessary for minor pain. According to the MAR, this prn pain medication had not been administered during the 22 hour period when the resident's ongoing complaints of pain were documented.

The review of resident #005's documentation concluded that they had complained of pain on three occasions after their fall and before their diagnosis of a fracture in

which pain assessments were missing.

The "Goals of Pain Management" in the home's Pain Management Toolkit, dated November 2010, directed staff that any resident who reported pain received an individualized documented pain assessment, treatment and education plan in regards to their pain.

The Inspector interviewed RPN #121 who had documented the resident's complaints of pain on two of the three instances in the 22 hour period. The RPN stated the resident received scheduled pain medication, but if ineffective, a pain assessment should have been completed with follow up prn analgesics.

During an interview with RN #137 who had submitted the CI report, they stated to the Inspector that from the resident's very first complaint of pain after their fall, the registered staff should have assessed the resident and implemented an appropriate intervention such as the administration of prn analgesics.

During an interview with the DOC, they stated to the Inspector in a separate interview that when resident #005 experienced ongoing pain, they should have been monitored post-fall with appropriate assessments and interventions provided for comfort and pain relief. [s. 52. (2)]

2. Inspector #616 reviewed a CI report that had been submitted to the Director related to an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CI report identified that resident #003 had sustained a fracture although the resident had denied a fall, and the home had no record of falls from the resident's admission to the date of transfer to hospital with a fracture diagnosis.

Inspector #616 reviewed progress notes related to the resident's suspected fall and found an "Admission" note documented by an RN indicating that resident #003 had a history, and was at that time being treated for a specific illness. A PSW had documented that they had reported resident #003's complaint of pain to the RPN on duty. There was no further documentation indicating registered staff actions or interventions related to this pain complaint in the progress notes related to the resident's complaint of pain on that particular day.

The Inspector reviewed the "Pain" focus of the Resident Profile and 24 hour Care Plan (in effect for up to 21 days post admission) for resident #003. None of the

sections that identified whether the resident experienced pain, the frequency, the severity, and treatment including non-pharmacological and pharmacological had been completed.

There was no record of a clinical pain assessment in the resident's electronic health record related to the resident's complaint of pain as documented by the PSW.

RPN #125 stated that when a PSW reported a resident was experiencing pain, they conducted a pain assessment and followed up with an intervention for pain management. RN #103, stated to the Inspector that following the PSW's report to the RPN on duty of resident #003 experiencing pain, the RPN should have completed an electronic pain assessment in the resident's electronic health record, or a progress note documenting what actions they took. They verified that a pain assessment had not been completed related to the resident's complaint of pain nor was any follow up by registered staff regarding resident #003's complaint of pain documented in progress notes.

CM #136 verified to the Inspector, that it was expected that registered staff responded to a resident's complaint of pain through assessment of the pain, implementation of interventions to manage their pain and documentation of the same. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an outbreak of a reportable disease as defined in the Health Protection and Promotion Act, followed by the report required under subsection (4).

On a specific date, the Thunder Bay District Health Unit (TBDHU) declared an enteric illness outbreak in the home. The home did not report this to the Director until six days after the outbreak was declared by the TBDHU, when they submitted a CI report.

Inspector #617 interviewed the DOC who confirmed that the enteric outbreak was declared by the TBDHU on the specific date, involving residents in two specific home areas. The DOC confirmed that in the absence of the Clinical Manager for both home areas, CM #165 had not reported the outbreak to the Director. [s. 107. (1) 5.]

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 Director is immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a reportable disease as defined in the Health Protection and Promotion Act, and followed by the report required under subsection (4), to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Inspector #616 reviewed progress notes related to a fracture resident #003 sustained as identified in a CI report submitted by the home to the Director. An "Admission" note documented by an RN identified that the resident had a history, and were at that time, being treated for a specific illness. Over a period of 12 days from the resident's admission to the home, to when they were transferred to hospital, the Inspector found five progress notes where the resident's complaints of pain were documented.

The Inspector reviewed medication orders related to resident #003's pain management and found that the physician had ordered a specific pain medication to be administered twice daily as needed (PRN) for three days. Another pain medication was also ordered by the physician which indicated to administer a specific dosage by mouth, twice daily, PRN.

There was no care planned focus for pain in effect at this time.

The Medication Administration Record was reviewed by the Inspector related to pain management follow up by registered staff where resident #003 was administered PRN medication on two separate occasions. Registered staff had documented the effectiveness of the pain medication only once. The Inspector found a follow up progress note that indicated the PRN pain medication administered, had been effective (six days after administration and during the time resident #003 was in hospital).

Both RN #103 and RPN #125 stated during separate interviews with the Inspector, that when a PRN analgesic was administered for pain, follow up and documentation was required by registered staff regarding the effectiveness of the medication.

During an interview with CM #136, they confirmed to the Inspector that registered staff should have responded to a resident's complaint of pain through assessment, implementation of interventions to relieve pain such as the administration of PRN medications. Further, they stated that registered staff were expected to document their interventions, including follow up to the effectiveness of the PRN medication. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, 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, without in any way restricting the generality of the duty provided for in section 19, that their written policy in place to promote zero tolerance of abuse and neglect of residents, was complied with.

Additional Required Actions will be addressed in WN #2 Duty to Protect, Compliance Order #002.

The home submitted a Critical Incident (CI) report regarding an incident of alleged staff to resident abuse. The CI report indicated that an email from PSW #146 was received by the home regarding seven allegations of abuse to residents by PSW staff including alleged physical, emotional and verbal abuse.. Please refer to WN #2 for further details.

In an interview with PSW #146, they confirmed to the Inspector that they had sent an email to VP #145, on a specific date, regarding concerns of inappropriate care of residents that was witnessed by other staff members. PSW #146 further confirmed that their concerns detailed in the email were incidents of alleged physical and emotional abuse that required to be reported immediately to the

registered staff or the Clinical Manager as per home’s policy. PSW #146 further explained that they did not follow the home’s policy in the reporting procedure as this matter as the report would not have remained confidential and that the DOC was fairly new at the time. PSW #146 chose to notify VP #145 of the matter for it to be addressed and remain confidential.

A review of the home's investigation notes indicated that VP #145, had been sent an email describing the concerns of alleged staff to resident abuse on unit a specific unit in the home, on a specific date, and VP #145 had acknowledged receipt of the email three days later.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect- #LTC 5-51", dated February 2016, indicated that all employees and affiliated personnel were required to fulfill their moral and/or legal obligation to report an incident of resident abuse to their manager/designate. Any employee or board member who was aware of or suspects abuse of a resident by anyone, or neglect of a resident by an employee, were to report it as soon as possible in accordance with the reporting procedures.

In an interview with VP #145 they confirmed to the Inspector that the allegations reported by PSW #146 were incidents of physical and emotional abuse that were required to be reported to the registered staff or Clinical Manager for immediate reporting to the Director. VP #145 further confirmed to the Inspector that PSW #146 did not follow the home’s policy in reporting the allegations of abuse which resulted in late reporting to the Director. VP #145 confirmed to the Inspector that when they had become aware of the critical incident on a specific date, after reading the email sent, they were required to immediately report to the Director on that date, but didn't, resulting in late reporting. [s. 20. (1)]

2. The home submitted a CI report regarding staff to resident verbal abuse. The CI report indicated that PSW #149 and PSW #150 reported to CM #152 that agency PSW #151 had acted disrespectfully and used profanity towards resident #014 while providing care. The incident occurred on a specific date, and was not reported to the CM #152 until one day later.

In an interview with PSW #153 they confirmed to the Inspector that the home’s policy for zero tolerance of abuse required them to immediately report to the registered staff or the Clinical Manager (CM) any suspicion of resident abuse.

Inspector interviewed the DOC who confirmed to the Inspector that the CI report of verbal and emotional abuse of resident #014 by agency PSW #151 was a mandatory report that was required to be reported immediately on the date that the incident had occurred, by PSW #149 and PSW #150 to CM #152. The DOC further confirmed to the Inspector that both PSW #149 and PSW #150 did not follow the home's policy on mandatory reporting resulting in late reporting to the Director. [s. 20. (1)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that appropriate action was taken to every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee.

Additional Required Actions will be addressed in WN #2 Duty to Protect, Compliance Order #002.

The home submitted a Critical Incident (CI) report regarding an incident of alleged staff to resident abuse. The CI report indicated that an email from PSW #146 was received by the home regarding seven allegations of abuse to residents by PSW staff including alleged physical, emotional and verbal abuse. Please refer to WN #2 for further details.

In an interview with the DOC, they clarified to the Inspector that the initial report by the staff member did not identify the names of residents or staff members involved. The home conducted their preliminary investigation and determined on a specific date, that PSW #148 was implicated in the allegations of abuse toward two residents in a specific home area.

A review of the home's investigation indicated that 16 days after receiving the allegation, the home concluded, PSW #148's actions towards residents #010 and #038 on three out of the seven allegations, were found to be abusive.

In an interview with the DOC, they confirmed to the Inspector that the home's investigation concluded that PSW #148 did abuse residents #010 and #038 and had conducted their investigation over a period of 11 days after becoming aware of the allegation.

A review of the home's census indicated that both residents #010 and #038 resided on a specific unit during the period of 11 days when the home had conducted their investigation.

A review of the staffing schedule submitted by the DOC during that 11 day period, indicated that PSW #148, continued to work on the specific unit with residents #010 and #038, following the allegation of abuse, for five shifts.

A review of the home's policy titled "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21", dated January 6, 2017,

indicated that all reported incidents of client abuse were to be investigated immediately. The Manager of the service where the client was receiving care had the primary responsibility for the initial investigation and to ensure the client was protected from further contact with the implicated staff.

Both the Inspector and DOC reviewed PSW #148's work schedule and the home's policy on "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff". The DOC confirmed to the Inspector that the home failed to protect residents #010 and #038 from further contact with PSW #148. The PSW continued to work on the specific unit for five shifts over the period of 11 days, during the time of the investigation. The DOC explained that the staff member should have been removed from the home during this time. [s. 23. (1) (b)]

2. The home submitted to the Director a Critical Incident (CI) report regarding incompetent/improper treatment of a resident by a PSW. The incident was reported to the MOH LTC After Hours pager on a particular day. The CI report indicated that resident #015 disclosed to a family member, that a PSW was verbally abusive to them, and that resident #015 was afraid of reporting this incident as they would "not get the care they needed". The CI report indicated that resident #015's family member had reported this incident to the home and the time the incident had occurred and the identification of the PSW was unknown.

A review of the home's investigation by Inspector #617, identified that PSW #154 was implicated in the incident and there was no indication of a conclusion to the investigation of incompetent treatment of resident #015. The contents of the investigation contained only an interview with RN #137 and PSW #154, on a specific date.

In an interview with both the DOC and RN #137, they reported to the Inspector that during the time that this incident had occurred, RN #137 was the interim CM of the unit where resident #015 was residing and PSW #154 was working. The DOC clarified to the Inspector that five days after the home was made aware of the incident, they had completed their investigation, and concluded that the allegation of incompetent treatment was not founded.

A review of PSW #154's work schedule during the five day period of the home's investigation, indicated that the PSW had worked on the specific unit for 12 hours where resident #015 resided.

The Inspector interviewed resident #015 who reported that PSW #154 had provided them with care and that sometimes there were issues with the care provided but the resident was not able to further elaborate.

During an interview with both the DOC and RN #137, they reviewed PSW #154's work schedule, and confirmed to the Inspector that PSW #154 did work on the specific unit for one shift during the time of the investigation when they were alleged to have provided incompetent treatment to resident #015.

Both the Inspector and DOC reviewed the home's policy "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21" and the DOC confirmed to the Inspector that PSW #154 who was implicated with an allegation of incompetent treatment of resident #015 was not removed from work, and the home did not protect the resident during the time of the investigation. [s. 23. (1) (b)]

3. The home submitted to the Director a CI report regarding staff to resident verbal abuse. The CI report indicated that a staff member was overheard by a co-resident speaking to resident #031 in a "not normal" tone. The staff member was heard to have aggressively and repetitively requested the resident to perform an action. The CI report indicated that seven days after the incident had occurred, the home notified the Director.

A review of the home's investigation notes by Inspector #617, indicated that resident #031's Substitute Family Member (SDM) reported the incident to the CM #138 on a specific date, which identified the implicated staff member as RPN #113. The investigation did not indicate a conclusion to the home's investigation of verbal abuse to resident #031.

In an interview with CM #138 they confirmed to the Inspector that on a specific date, they were made aware of an allegation of verbal abuse had occurred with resident #031.

A review of the home's investigation indicated that six days after CM #138 was aware that RPN #113 was involved in an allegation of verbal abuse, the RPN was no longer an employee of the home.

A review of RPN #113's work schedule during the time the home conducted their investigation over a period of six days, indicated that they had worked on the unit

where resident #031 resided for three eight hour shifts.

In an interview with CM #138 they reviewed RPN #113's work schedule and confirmed to the Inspector that the RPN did work on the unit and had contact with resident #031 during three shifts during the period of six days when the investigation was conducted.

In an interview with the DOC, they confirmed to the Inspector that the critical incident involving the allegation of RPN #113 verbally abusing resident #031 was a mandatory report and even though the home was not able to conduct a thorough investigation, there was enough evidence to conclude that abuse of resident #031 did occur.

Both the Inspector and CM #138 reviewed the home's policy titled, "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21", and the CM confirmed to the Inspector that the policy of the home was to remove RPN #113 who was alleged to have provided incompetent treatment to resident #031, from work, to protect the resident during the time of the investigation. CM #138 further confirmed that resident #031 was not protected from further contact with the implicated staff. [s. 23. (1) (b)]

4. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Inspector #613 reviewed a CI report submitted to the Director on a particular date, which identified physical abuse between resident #017 and #018. The CI report revealed that resident #018 had an altercation with resident #017 resulting in an injury to resident #017.

Inspector #613 reviewed the CI report which had not been amended to include the outcome of the home's investigation.

A review of policy titled, "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse and Neglect" last revised February 2016, identified that the Director/designate and/or VP Senior Health /Senior Administration was accountable for overseeing that the proper reporting to Director had been undertaken. The report included, but was not limited to, the results of the investigation and any action in response to incident of abuse.

During an interview on August 16, 2017, with the Director of Care, they confirmed that the CI report had not been updated with the outcome of the investigation and reported to the Director. [s. 23. (2)]

5. Inspector #613 reviewed a CI report that was submitted to the Director on a specific date, which identified physical abuse between resident #022 and #019. The CI report revealed that resident #019 and resident #022, had an altercation, which resulted in an injury to resident #022.

Inspector #613 reviewed the CI report which had not been amended to include the outcome of the home's investigation.

During an interview on August 16, 2017, with the Director of Care, they confirmed that the CI report had not been updated with the outcome of the investigation and reported to the Director. [s. 23. (2)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Additional Required Actions will be addressed in WN #2 Duty to Protect, Compliance Order #002.

Inspector #613 reviewed a CI report that was submitted to the Director on a specific date, identifying physical abuse with injury. The CI report described that resident #019 and resident #020 had an altercation, resulting in injury to resident #020.

The Inspector reviewed the home's investigation notes. According to the progress notes and the CI report, resident #020 sustained physical injuries, and at that time, the RN was informed of the incident.

A review of policy titled, "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse and Neglect" last revised

February 2016, identified that all employee and affiliated personal were required to fulfill their moral and/or legal obligation to report an incident or alleged incident of resident abuse immediately to their Manager/designate. The Director/designate and /or VP Seniors' Health was to be notified immediately and they would notify the Ministry by phone. As well, a review of the home's form titled, "RN Long Term Care Communication Guidelines" revised May 2017 identified that during business hours the RN on duty was to notify the Clinical Manager of abuse. When abuse occurred after business hours, on weekends and on statutory holidays, the RN on duty was responsible to notify the Director using the Ministry of Health and Long Term Care (MOHLTC) After Hours pager of resident abuse.

During an interview on August 16, 2017, with the DOC, they indicated that the RN was in charge of the unit and was expected to notify the MOHLTC After Hours pager as well as the Manager on call, at the time the incident occurred. The DOC confirmed that the Director was not immediately notified by the RN of this incident, and that the incident was reported late to the Director. [s. 24. (1)]

2. Inspector #613 reviewed a CI report submitted to the Director on a specific date, identifying physical abuse with injury to resident #023. The CI report described that resident #023 and resident #019 had an altercation which resulted in an injury to resident #023.

The Inspector reviewed the home's investigation notes and according to the progress notes when resident #023 sustained physical injuries on a specific date the RN was informed of the incident on that date.

During an interview on August 16, 2017, with the Director of Care, they indicated that the RN was expected to notify the Director using the MOHLTC After Hours pager, as well as the Manager on call, at the time the incident had occurred. The DOC confirmed that the Director was not immediately notified by the RN of this incident, and that the incident was reported late to the Director. [s. 24. (1)]

3. The home submitted a CI report regarding an incident of alleged staff to resident abuse. The CI report was submitted on a specific date, to the MOH LTC After Hours pager by the DOC. The CI report indicated that an email from PSW #146 was received, regarding seven allegations of abuse to residents by PSW staff. Please refer to WN #2 for further details.

A review of the home's investigation notes indicated that on a specific date, PSW

#146 had emailed VP #145, detailed concerns of alleged staff to resident abuse on a specific unit, and that three days later, VP #145 had acknowledged receipt of the email and forwarded it to both CM #147 and the DOC.

In an interview with PSW #146, they confirmed to the Inspector that they had sent an email to VP #145 on a certain date, regarding their concerns of PSWs' inappropriate actions and residents' care that was witnessed by other staff members. PSW #146 further confirmed that their concerns detailed in the email were incidents of alleged physical and emotional abuse that were required to be reported immediately.

The CI report was submitted three days after the home was made aware of the allegation of resident abuse when VP #145 had acknowledged receiving the email from PSW #146.

A review of the home's policy titled, "Zero Tolerance of Abuse and neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect- #LTC 5-51", dated February 2016, indicated that all employees and affiliated personnel were required to fulfill their moral and/or legal obligation to report an incident of resident abuse to their manager/designate. The Director/designate and/or or Vice President of Seniors' Health must be notified immediately and they were required to notify the Director by phone. Notification was to be followed by immediate initiation of the report using the CI System.

In an interview with VP #145 they confirmed to the Inspector that the allegations reported by PSW #146 were incidents of physical and emotional abuse that required to be reported immediately to the Director. VP #145 further clarified that they were aware of the allegation of resident abuse, and was required to immediately report the suspicion to the Director but did not, which resulted in late reporting. [s. 24. (1)]

4. The home submitted a CI report to the Director regarding staff to resident verbal abuse. The CI report indicated that a staff member was overheard by a co-resident speaking to resident #031 in a "not normal" tone. The staff member was heard to have aggressively and repetitively requested the resident to perform an action. The CI report indicated that the incident occurred seven days before the CI report was submitted to the Director.

A review of the home's investigation by Inspector #617 indicated that CM #138 was

approached by resident #031's Substitute Decision Maker (SDM) on a specific date, and that the information presented to the clinical manager, at that time, identified the staff member and the dates when the critical incident occurred.

In an interview with CM #138 they confirmed to the Inspector that on a specific date, they were made aware of an allegation of verbal abuse that had occurred with resident #031 and reported the critical incident five days later to the Director.

In an interview with the DOC they confirmed to the Inspector that the critical incident involving the allegation of RPN #113 verbally abusing resident #031 was a mandatory report, and was required to be reported immediately to the Director, by CM #138, and that it was reported late. [s. 24. (1)]

5. During the inspection, resident #040's family member reported to Inspector #617 that on a certain date, resident #037 had been physically aggressive with resident #040, resulting in injury to resident #040.

Inspector #617 reviewed resident #037's progress notes which confirmed that on that specific date, a physical altercation had occurred between residents #037 and #040 resulting in injury to resident #040, and both residents' Substitute Decision Makers (SDMs) were notified.

On August 24, 2017, a review of the Long Term Care Homes Critical Incident reporting system identified that the home had not yet submitted a Critical Incident report regarding the suspected abuse of resident #040 by resident #037.

On August 25, 2017, Inspector #617 interviewed the DOC, who reviewed resident #037's progress note dated on that specific date, and confirmed that the incident where both residents #037 and #040 had a physical altercation resulting in injury to resident #040, were required to be immediately reported to the Director, and were not yet reported.

The home submitted a Critical Incident report to the Director regarding resident to resident physical abuse which indicated that on a specific date, RPN #130, witnessed a physical altercation between resident #037 and resident #040. RPN #130 separated the residents and discovered an injury to resident #040. The CI report was submitted five days after the critical incident had occurred.

In an interview with RPN #130, they confirmed to the Inspector the date and the

details of the incident as identified in the CI report.

Both the Inspector and RPN #130 reviewed the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents-#LTC 5-50", dated February 2016, regarding the definition of physical abuse, and RPN #130 confirmed to the Inspector that residents #037 and #040's altercation met the policy definition and was required to be reported to the Director Immediately.

In an interview with RPN #130 they confirmed to the Inspector that they followed the reporting procedure of the home and completed and submitted a safety report to CM #138 and notified on-duty RN #171, on the day the incident had occurred.

Inspector #617 interviewed CM #138 who confirmed that the incident between resident #037 and #040 met the definition of physical abuse resulting in injury after reviewing the home's policy for zero tolerance of abuse that was required to be immediately reported to the Director. CM #138 further explained that they had expected RN #171 to call the MOHLTC After Hours pager and report the incident to the Director at the time the incident occurred and they were notified, and they failed to do so resulting in late reporting to the Director.

In an interview with CM #138, they confirmed to the Inspector they were aware one day after the incident had occurred, when they had read the safety report submitted by RPN #130. CM #130 further explained that at that time, they did not recognize resident #040's injury as a form of abuse, they discussed the incident at the manager's meeting and they were not given direction to report the incident on that day. CM #138 confirmed to the Inspector that as a result, the notification to the Director was late. [s. 24. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that subject to subsection (3), the licensee submitted the written report within 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse of a resident by anyone, or at an earlier date if required by the Director.

Additional Required Actions will be addressed in WN #2 Duty to Protect, Compliance Order #002.

The home submitted to the Director a CI report regarding incompetent/improper treatment of a resident that resulted in risk of harm to a resident. The incident was reported to the MOHLTC After Hours pager initially on a specific date, and the home then submitted the written report to the Director 26 days later.

The CI report indicated that resident #015 disclosed to their family member, that while the resident was in the tub room a PSW was verbally abusive and that resident #015 was afraid of reporting this incident. The CI report indicated that resident #015's family member had reported this incident to the home, and that the time the incident had occurred and the identification of the PSW was unknown.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications about Incidents of Abuse or Neglect-#LTC 5-51", revised on February 2016, which indicated that it was the Director/designate and/or VP Seniors' Health responsibility once notified of an incident of improper or incompetent treatment or care of a resident, they were required to notify the Director by phone. Notification was to be followed by immediate initiation of the report using the on line Critical Incident System. The CI report was to be finalized and submitted within 10 days following awareness of the incident or an earlier date if required by the Director.

In an interview with both the DOC and RN #137, they reported to the Inspector that

during the time that this incident had occurred, RN #137 was the Interim Manager of the unit where resident #015 was residing and PSW #154 was working. The DOC clarified to the Inspector that after they had reported the incident to the Director, they had instructed RN #137 to manage the investigation. RN #137 reported to the Inspector that they had completed their investigation five days after the incident had occurred, and concluded that the allegation of incompetent treatment was not substantiated.

In an interview with the DOC they confirmed to the Inspector that they had submitted the CI written report to the Director 26 days after the initial report was submitted to the Director, as submitting the written CI report for this incident had "fallen through the cracks." The DOC further explained that RN #137 was the Interim Manager of the implicated unit and at the time the incident was reported and the investigation was conducted, RN #137 did not have access to the CI reporting online site. [s. 104. (2)]

Issued on this 27 day of December 2017 (A3)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : RYAN GOODMURPHY (638) - (A3)

Inspection No. / No de l'inspection : 2017_509617_0017 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 005392-17, 005872-17, 008322-17, 008329-17, 009350-17, 009450-17, 009475-17, 010165-17, 010285-17, 011409-17, 012578-17, 013222-17, 013754-17, 014266-17, 014321-17, 014579-17, 014625-17, 015338-17, 016185-17, 016793-17, 017522-17, 018064-17, 018284-17, 019633-17, 020917-17 (A3)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Dec 27, 2017;(A3)

Licensee / Titulaire de permis : ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD :

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

Ministère 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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON, P7C-4Y7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Judy Plummer

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To ST. JOSEPH'S CARE GROUP, 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. 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the written plan of care for, resident #005 and resident #006 and all other residents residing in the home, is updated with all fall prevention interventions being provided to the resident.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there was a written plan of care for resident #006 that set out, the planned care for resident #006 and resident #005 regarding fall prevention interventions.

The home submitted a Critical Incident (CI) report whereby resident #006 fell and was taken to hospital resulting in a significant change in the resident's health status.

The CI report indicated that resident #006 had an unwitnessed fall in their bedroom and then two days later was assessed by PT #129 to have pain from their fall. Once informed of the resident's pain the physician ordered an x-ray which, confirmed that resident #006 had a fracture.

A review of resident #006's Resident Assessment Minimal Data Set (RAI MDS) by Inspector #617, indicated that the resident required a specific level of assistance from staff, and required the use of a mechanical lift for transfers. A review of resident #006's care plan specifically related to falls indicated that the resident was assessed as a high risk for falling, and required specific fall prevention interventions. A review of resident #006's health care records indicated that since their fall addressed in the aforementioned CI report, they had five subsequent falls where significant injuries were sustained.

On August 30, 2017, Inspector #617 observed resident #006 without two specific fall prevention interventions initiated, as advised in the plan of care. Again, on the same day, Inspector #617 observed resident #006's room and identified that numerous fall prevention interventions were not initiated.

On August 30, 2017, the Inspector interviewed PSW #133 who reported that resident #006 had many falls as they were known to self-transfer and did not have the ability transfer safely. PSW #133 further reported that there were a number of fall prevention interventions provided by staff to prevent the resident from falling.

A review of resident #006's post fall assessments related to the five falls that occurred after the critical incident, a total of nine fall prevention interventions had not been initiated as indicated in the plan of care.

On August 30, 2017, in an interview with RPN #130, they reported to the Inspector that after each resident fall, the registered staff were expected to complete a post fall assessment, collaborate with the team to determine what had happened during the fall, review the post fall assessment data and update the care plan accordingly.

During the interview with the Inspector, PSW #133 described five individual fall prevention interventions within the resident's written plan of care.

In an interview with Clinical Manager (CM) #135, they reported that the information determined from the resident's post fall assessment was to be reviewed by the team

and updated in their written care plan. CM #135 then confirmed that the information determined by the post fall assessments completed for resident #006's five falls, and the nursing interventions currently provided should have been updated in their care plan. [s. 6. (1) (a)]

2. RN #137 had submitted a CI report to the Director for resident #005's unwitnessed fall from their bed. As a result of the fall, the CI report identified that the resident sustained a fracture.

Inspector #616 reviewed the resident's care plans related to falls prevention in effect prior to the incident as well as the most current care plan. In both care plans the resident was identified at high risk for falls.

The Inspector reviewed progress notes and the post-fall assessment documented after the resident's fall by RPN #121, and the "shift to shift" reports where it was identified how resident #005's fall occurred.

On August 24 and 25, 2017, respectively, PSWs #158 and #159 both reported separately to Inspector #616 that they were aware of resident #005's high fall risk. PSW #158 described an intervention they had implemented to keep the resident safe. Both PSW #158 and PSW #159 stated that resident #005's care plan did not clearly identify the intervention they implemented as a falls prevention intervention. RPN #121 also stated that the intervention that PSW #158 used was effective as mitigating a risk of falling for the resident and confirmed the described intervention was not in place at the time of the incident.

On August 24, 2017, during an interview with RN #137, they confirmed to the Inspector that the omission of the described intervention did not clearly identify the planned care for resident #005. [s. 6. (1) (a)]

The decision to issue this Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, although the scope was isolated, the severity of actual harm to residents who have fallen, was determined. The home has a history of non-compliance in this area of the legislation as follows:

-a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection (RQI) #2017_624196_0005 issued on March 21, 2017, and
-a VPC during RQI Inspection #2016_435621_0012 issued on July 7, 2016. (617)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Dec 31, 2017(A2)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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 is ordered to ensure:

1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
i) improper or incompetent treatment of a resident that resulted in harm or a risk of harm to the resident,
ii) abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,
iii) unlawful conduct that resulted in harm or a risk of harm to a resident,
iv) misuse or misappropriation of a resident's money,
x) misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act.

2) The home's written policy to promote zero tolerance of abuse is reviewed and revised to ensure it complies with the requirements of the LTCHA and O. Reg 79/10 and is complied with.

3) Appropriate action is taken in response to every incident of alleged, suspected or witnessed abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

Grounds / Motifs :

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

1) Pursuant to the LTCHA, 2007, s 20 (1), the home had failed to ensure on two separate occasions that their written policy to promote zero tolerance of abuse and neglect of residents was complied with specific to their procedure for reporting allegations of abuse.

a) The home submitted a Critical Incident (CI) report regarding an incident of alleged staff to resident abuse. The CI report indicated that an email from PSW #146 was received by the home regarding seven allegations of abuse to residents by PSW staff including alleged physical, emotional and verbal abuse.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect of

Residents Reporting and Notifications About Incidents of Abuse or Neglect- #LTC 5-51", dated February 2016, indicated that all employees and affiliated personnel were required to fulfill their moral and/or legal obligation to report an incident of resident abuse to their manager/designate. Any employee or board member who was aware of or suspects abuse of a resident by anyone, or neglect of a resident by an employee, must report it as soon as possible in accordance with the reporting procedures.

A review of the home's investigation notes indicated that VP #145, had been sent an email describing the concerns of alleged staff to resident abuse on a specific date, and VP #145 had acknowledged receipt of the email three days later.

In an interview with VP #145 they confirmed to the Inspector that the allegations reported by PSW #146 were incidents of physical and emotional abuse that were required to be reported to the registered staff or Clinical Manager for immediate reporting to the Director. VP #145 further confirmed to the Inspector that PSW #146 did not follow the home's policy in reporting the allegations of abuse which resulted in late reporting to the Director.

b) The home submitted a CI report regarding staff to resident verbal abuse. The CI report indicated that PSW #149 and PSW #150 reported to CM #152 that agency PSW #151 had acted disrespectfully and used profanity towards resident #014 while providing care. The incident occurred on a specific date, and was not reported to the CM #152 until one day later.

Inspector #617 interviewed the DOC who confirmed to the Inspector that the CI report of verbal and emotional abuse of resident #014 by agency PSW #151 was a mandatory report that was required to be reported immediately by PSW #149 and PSW #150 to their CM #152. The DOC further confirmed to the Inspector that both PSW #149 and PSW #150 did not follow the home's policy on mandatory reporting resulting in late reporting to the Director.

Non-compliance related to s. 20 (1), of the LTCHA, 2007, is being issued in WN #14.

2) Pursuant to the LTCHA, 2007, s. 23 (1), the licensee failed on three occasions to ensure that appropriate action was taken to every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee.

a) On the first occasion, the home submitted a Critical Incident (CI) report regarding an incident of alleged staff to resident abuse. The CI was reported on a specific date, to the Ministry of Health and Long Term Care (MOHLTC) After Hours pager, by the DOC. The CI report was submitted to the Director nine days after it occurred, and indicated that the home received the allegation from a staff member 15 days before the report to the Director was submitted, that seven allegations of abuse to residents by PSW staff had occurred. Please refer to WN #2, finding #1a, for further details, pertinent to the CI report.

In an interview with the DOC, they clarified to the Inspector that the initial report by the staff member did not identify the names of residents or staff members involved. The home conducted their preliminary investigation and determined that PSW #148 was implicated in the allegations of abuse toward two residents.

A review of the home's investigation indicated that 16 days after receiving the allegation, the home concluded, PSW #148's actions towards residents #010 and #038 on three out of the seven allegations, were found to be abusive.

In conclusion the home had conducted their investigation over a period of 11 days after becoming aware of the allegation. A review of the staffing schedules and interviews with the DOC confirmed that the home failed to protect resident #010 and resident #038 from having contact with PSW #148, during the time of the investigation, and did not remove the PSW from working on the resident's respective units for five occasions, placing both residents at risk.

b) On the second occasion, the home submitted to the Director a Critical Incident (CI) report regarding incompetent/improper treatment of a resident by a PSW. The incident was reported to the MOH LTC After Hours pager on a particular day. The CI report indicated that resident #015 disclosed to a family member, that a PSW was verbally abusive to them, and that resident #015 was afraid of reporting this incident as they would "not get the care they needed". The CI report indicated that resident #015's family member had reported this incident to the home and the time the incident had occurred and the identification of the PSW was unknown.

A review of the home's investigation by Inspector #617, identified that PSW #154 was implicated in the incident and there was no indication of a conclusion to the investigation of incompetent treatment of resident #015.

In an interview with both the DOC and RN #137, they reported to the Inspector that during the time that this incident had occurred, RN #137 was the interim CM of the unit where resident #015 was residing and PSW #154 was working. They clarified to the Inspector that the home was made aware of the incident on on the particular day (when reported to the MOHLTC), and had completed their investigation five days later when it was concluded that the allegation of incompetent treatment was not founded.

Both the Inspector and DOC reviewed the home's policy "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21" and the DOC confirmed to the Inspector that PSW #154 who was implicated with an allegation of incompetent treatment of resident #015 was not removed from work, and the home did not protect the resident during the time of the investigation.

c) On the third occasion, the home submitted to the Director a CI report regarding staff to resident verbal abuse. The CI report indicated that a staff member was overheard by a co-resident speaking to resident #031 in a "not normal" tone. The staff member was heard to have aggressively and repetitively requested the resident to perform a specific action. The CI report indicated that the incident occurred on a certain day, and was submitted one week later.

A review of the home's investigation notes by Inspector #617, indicated that resident #031's Substitute Family Member (SDM) reported the incident to the CM #138 two days after the incident occurred, which identified the implicated staff member as RPN #113. The investigation did not indicate a conclusion to the home's investigation of verbal abuse to resident #031.

Both the Inspector and CM #138 reviewed the home's policy titled, "Respect and Safety in the Workplace Program: Managing the Abuse of Clients by Staff - AD 6-21", and the CM confirmed to the Inspector that the policy of the home was to remove RPN #113 who was alleged to have provided incompetent treatment to resident #015, from work, to protect the resident during the time of the investigation. CM #113 further confirmed that resident #031 was not protected from further contact with the implicated staff member.

Non-compliance related to s. 23 (1) (b), of the LTCHA, 2007, is being issued in WN #15.

3) Pursuant to LTCHA, 2007, s. 23 (2), the licensee had failed to ensure that the results of the abuse or neglect investigation were reported to the Director on two separate occasions.

a) On the first occasion, Inspector #613 reviewed a CI report that was submitted to the Director on a specific date, which identified physical abuse between resident #017 and #018 that resulted in an injury to resident #017.

b) On the second occasion, Inspector #613 reviewed a CI report that was submitted to the Director on another particular date, which identified physical abuse between resident #022 and #019, which resulted in resident #022 sustaining an injury.

During an interview on August 16, 2017, with the Director of Care, they confirmed to the Inspector that both CI reports had not been updated with the outcome of the investigation and reported to the Director.

Non-compliance related to s. 23 (2), of the LTCHA, 2007, is being issued in WN #15.

4) Pursuant to the LTCHA, 2007, s 24 (1), the licensee had failed to ensure that on five occasions, the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

a) On the first occasion, Inspector #613 reviewed a CI report submitted to the Director on a specific date, identifying physical abuse with injury. The CI report described an injury to resident #020 which was caused by resident #019.

During an interview on August 16, 2017, with the DOC, they indicated that the RN was in charge of the unit and was expected to notify the MOHLTC After Hours pager as well as the Manager on call, the day of which the incident occurred. The DOC confirmed that the Director was not immediately notified by the RN of this incident until one day later when it was reported late to the Director.

b) On the second occasion, Inspector #613 reviewed a CI report submitted to the Director on a specific date, identifying physical abuse with injury to resident #023.

During an interview on August 16, 2017, with the Director of Care, they indicated that the RN was expected to notify the Director using the MOHLTC After Hours pager, as well as the Manager on call, on the day the incident occurred. The DOC confirmed that the Director was not immediately notified by the RN of this incident two days later when the incident was reported late to the Director.

c) On the third occasion, the home submitted a CI report regarding incidents of alleged staff to resident abuse. The CI report was submitted on a particular date, to the MOHLTC After Hours pager by the DOC. The CI report was submitted to the Director nine days later, and indicated that an email from PSW #146 was received six days prior to the initial report to the MOHLTC, regarding seven allegations of abuse to residents by PSW staff. Please refer to WN #2 for further details.

In an interview with VP #145 they confirmed to the Inspector that the allegations reported by PSW #146 were incidents of physical and emotional abuse that were required to be reported immediately to the Director. VP #145 further clarified that they were aware of the allegation of resident abuse the day when they acknowledged receiving the email from PSW #146, and were required to immediately report the suspicion to the Director but did not, which resulted in late reporting.

d) On the fourth occasion, the home submitted to the Director a CI report regarding staff to resident verbal abuse. The CI report indicated that a staff member was overheard by a co-resident speaking to resident #031 in a "not normal" tone. The staff member was heard to have aggressively and repetitively requested the resident to perform a certain activity. The CI report indicated that the incident occurred on a specific date, seven days before the CI report was submitted to the Director.

In an interview with the DOC they confirmed to the Inspector that the critical incident involving the allegation of RPN #113 verbally abusing resident #031 was a mandatory report, required to be reported immediately to the Director on the date it occurred, by CM #138, and that it was reported late.

e) On the fifth occasion, resident #040's family member reported to Inspector #617 that on August 20, 2017, resident #037 exhibited physically responsive behaviours resulting in injury to resident #040.

Inspector #617 reviewed resident #037's progress notes which confirmed that on a specific date, a physical altercation had occurred between residents #037 and #040

resulting in injury to resident #040.

On August 25, 2017, Inspector #617 interviewed the DOC, who reviewed resident #037's progress note, and confirmed that the incident where both residents #037 and #040 had a physical altercation resulting in injury to resident #040, was required to be immediately reported to the Director, and was not yet reported.

During the inspection, the home submitted a Critical Incident report to the Director regarding resident to resident physical abuse. The CI report indicated that on the specified date, RPN #130, witnessed a physical altercation between resident #037 and resident #040. RPN #130 then separated the residents and discovered an injury to resident #040. The CI report was submitted on a particular number of days after the critical incident had occurred.

In an interview with CM #138, they confirmed to the Inspector they were aware the day after the incident, of the incident that occurred on the specific day, after reading the safety report submitted by RPN #130. CM #130 further explained that at that time, they did not recognize resident #040's injury as a form of abuse, they discussed the incident at the manager's meeting and they were not given direction to report the incident, that day. CM #138 confirmed to the Inspector that as a result, the notification to the Director was late.

Noncompliance related to s. 24 (1), of the LTCHA, 2007, is being issued in WN #16.

5) Pursuant to O. Reg 79/10, s 104. (2), the licensee had failed to ensure that subject to subsection (3), the licensee submitted the written report within 10 days of becoming aware of the alleged, suspected or witnessed incident of abuse of a resident by anyone, or at an earlier date if required by the Director.

The home submitted to the Director a CI report regarding incompetent/improper treatment of a resident that resulted in risk of harm to a resident. The incident was reported to the MOHLTC After Hours pager initially on a particular day, and the home then submitted the written report to the Director 26 days later.

In an interview with the DOC they confirmed to the Inspector that they had submitted the CI written report to the Director 26 days after the initial report to the MOHLTC, as submitting the written CI report for this incident had "fallen through the cracks." The DOC further explained that RN #137 was the Interim Manager of the unit at the time

that the incident was reported and the investigation was conducted, and that RN #137 did not have access to the CI reporting online site.

Noncompliance related to s. 104. (2), of the Regulation, is being issued in WN #17.

6) Pursuant to the LTCHA, 2007, s. 76 (2), the licensee has failed to ensure that all staff at the home have received orientation training including but not limited to the home's policy to promote zero tolerance of abuse and duty to report as issued under WN #7, Compliance Order #007.

7) In interviews with the Inspector, newly hired CM #138 reported to the Inspector that their lack of experience with recognizing incidents that required them to take immediate action and report to the Director resulted in non-compliance. During an interview with the DOC they confirmed to the Inspector that during the time RN #137 was acting as Interim Manager, they did not have access to the Critical Incident System online reporting system, to report a critical incident referred in WN #16 of this report.

In interviews with the DOC they reported that the home has had management turnover over the last six months including the Administrator, DOC and CM positions.

In conclusion the licensee failed to protect residents from abuse and neglect by failure to: report, adhere to the home's zero tolerance of abuse policy, respond with appropriate actions to alleged, suspected or witnessed abuse and complete required orientation training. [s. 19. (1)]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the scope of a pattern, the severity of actual harm to residents who have been abused, was determined. The home has a history of noncompliance in this area of the legislation as follows:

-a CO during the Resident Quality Inspection (RQI) #2016_435621_0012 issued on November 25, 2016, and complied on January 20, 2017,
-a Voluntary Plan of Correction (VPC) during the Critical Incident System Inspection (CIS) #2016_391603_0022 issued on October 11, 2016, and
-a VPC during the RQI #2015_333577_0012 issued on October 29, 2015, and complied on February 2, 2016. (617)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Dec 31, 2017(A2)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The Licensee is ordered to ensure that:

1) Doors leading to stairways and the outside of the home are kept closed and locked,

2) Roam alert security is functioning on those doors leading to the outside of the facility,

3) Door security is tested to ensure functionality and records are kept of the testing.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were kept closed and locked.

Inspector #620 reviewed a CI report that was submitted to the Director, which described that on a particular day, both resident #026 and #025 were determined by staff to be missing from the home. The CI report described that resident #026 was capable of leaving the home; however, resident #025 was not capable; and as a result, resident #025 had interventions in place to prevent the resident from exiting the facility. The home determined that resident #025 left the home in the care of resident #026 but that while off site, resident #026 left resident #025 on their own. Resident #025 was found a distance away from the home and was returned unharmed. Resident #026 returned to the home on their own.

Inspector #620 interviewed the home's Security Guard who indicated that they recalled the incident when resident #025 and #026 went missing. They indicated that following the incident, they were advised that resident #026 was no longer allowed to leave the facility with resident #025. They indicated that following the incident resident #026 had tried to leave the facility with resident #025 through a particular exit in the home. The Security Guard indicated that this exit was the only door in the facility that would not lock when a resident with a particular intervention in place was in close proximity to the door. Therefore, resident #025 could be assisted by resident #026 to exit the home via the particular exit.

Inspector #620 tested the particular exit door, utilizing the particular intervention, and the Inspector was able to exit this particular door.

Inspector #620 observed that on August 16, 2017, at 0917 hours, the particular door was under repair by a contractor. At the time of the observation the door was observed to propped open. The door was left ajar from 0917 hours, to 1400 hours. The Inspector observed that the doorway was not being monitored by any staff member.

On August 16, 2017, Inspector #620 interviewed the home's Security Guard about the particular door being propped open. They indicated that while the door had been propped open, resident #030 had exited through this door. They indicated that resident #030 utilized the particular intervention and that they frequently tried to exit the home. They indicated that resident #030 returned to the home without incident.

Inspector #620 interviewed the home's DOC #140 who indicated that the home's particular door should not have been left open and unlocked. They indicated that it was expected that when repairs were being made to an exit door that maintenance staff were to remain onsite to secure the door. [s. 9. (1) 1. i.]

The decision to issue a Compliance Order (CO) was based on the home's ongoing non-compliance with this section of the legislation, the scope was widespread, the severity was of potential harm to residents able to exit to the outside with unlocked doors, was determined. The home had a history of non-compliance in this area of the legislation as follows:

- a VPC during the Complaint Inspection #2016_246196_0002 issued on January 21, 2016, and
- a WN during the Resident Quality Inspection #2014_246196_0016 issued on September 2, 2014. (620)

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

Dec 01, 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

Ministère 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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee is ordered to:

1) Ensure that two staff are present when operating all mechanical lifts assisting resident #003 and all residents who require two person lifts when transferring, and

2) Develop and implement an auditing process to ensure two staff are present when required;

3) Maintain records of the auditing results and actions taken when the mechanical lift is not operated with two staff when required; and

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home submitted a CI report to the Director for an incident that caused an injury to resident #003. In the CI report, PSW #116 transferred resident #003 using a specific mechanical lift when the resident slipped through the sling and onto the floor. The resident was transferred to hospital, diagnosed with a fracture, and returned to

the home.

Inspector #616 reviewed the home's investigation record that verified that resident #003 had sustained an injury as a result of PSW #116 performing a one person transfer using this specific mechanical lift when two staff were required during this transfer.

The Inspector reviewed the resident's transferring care plan which identified that resident #003 required a specific mechanical lift.

The Inspector reviewed the home's "Guidelines for Minimal Lift", undated, that referenced policy HR 7-223, where the "Mechanical Lifts" or mobile lifting devices, required two caregivers to operate.

During the Inspector's interviews with PT #117 and PSW #118 separately, they verified that any mechanical lifts, including the resident's specific mechanical lift required two staff, one to operate the lift, the other to monitor the resident. The PT confirmed to the Inspector the resident's care plan indicated that the resident required one person for assistance which was an unsafe practice using the specific mechanical lift.

During an interview with the DOC, they confirmed that resident #003's care plan that indicated the resident transferred by one staff using the specific mechanical lift was unsafe. [s. 36.]

The decision to issue a Compliance Order was based on the home's ongoing non-compliance unrelated to this section of the legislation, although the scope was isolated, the severity of actual harm to the resident that was transferred incorrectly, was determined. (616)

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

Feb 28, 2018(A3)

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

Ministère 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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee shall ensure:

1) Registered staff are following the home's falls prevention policy and completing a post fall assessment environmental screen document on Medecare each time a resident has fallen, and

2) Performance of the registered staff to ensure completion of the post fall assessment is audited and records are kept.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when residents #004, #006 and #007 had fallen, the residents were assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted a CI report whereby resident #007 had fallen causing an injury and was taken to hospital resulting in a significant change in their health status. The CI report indicated that resident #007 was found on the floor after attempting to self-transfer. The CI report also identified that both RN #132 and RN #164 assessed the

resident and that they suspected an injury. Resident #007 was sent to the hospital and they were diagnosed with a fracture.

A review of resident #007's post fall assessments indicated that an assessment was missing for the fall that had occurred.

In an interview with RAI Coord #131, on August 31, 2017, they confirmed to the Inspector that a post fall assessment was missing for the resident's fall.

A review of the home's policy titled, "Fall Prevention and Management Program - LTC 3-60", dated April 2014, indicated that registered staff were required to lead the team in completing the post fall assessment following each resident fall. The post fall assessment included the "Post Fall Screen for Resident/Environmental Factors" and the "Falls Assessment".

On August 31, 2017, in an interview with RPN #139, they reported to the Inspector that after each resident fall, the registered staff were expected to complete a post fall screen for resident/environmental factors assessment and a fall risk assessment on the electronic documentation system, Medecare. The registered staff were then expected to collaborate with the team to determine what had happened during the fall, review the post fall assessment data and update the care plan accordingly.

In an interview with CM #138, who reviewed the home's policy related to falls prevention with the Inspector and confirmed to the Inspector that registered staff were expected to have completed a post fall assessment for resident #007. CM #138 further confirmed that at the time of their fall resident #007 was to have interventions in place to prevent their falls and that the post fall assessment was required to be completed to determine the cause of the fall and to make changes to the care plan when necessary. [s. 49. (2)]

2. The home submitted a CI report to the Director whereby resident #006 had fallen and was taken to hospital resulting in a significant change in the resident's health status. The CI report indicated that resident #006 had an unwitnessed fall and then two days later were assessed by PT #129 to have pain as a result of their fall. Once informed of the resident's pain, the physician ordered an x-ray which, confirmed that resident #006 had sustained a fracture.

A review of resident #006's post fall assessments indicated that an assessment was

missing for their fall that had occurred.

In an interview with RAI Coord #131, on August 30, 2017, they reviewed resident #006's post fall assessments and confirmed that their post fall assessment was missing.

On August 31, 2017, in an Interview with RPN #130, they reported to the Inspector that after each resident fall, the registered staff were expected to complete a post fall screen for resident/environmental factors assessment and a fall risk assessment on the electronic documentation system, Medecare. The registered staff were then expected to collaborate with the team to determine what had happened at the fall, review the post fall assessment data and update the care plan accordingly.

Inspector #617 interviewed the DOC, on August 30, 2017, who confirmed that resident #006 fell and were later discovered to have sustained a fracture; the registered staff should have completed a post falls assessment. [s. 49. (2)]

3. A CI report was received by the Director concerning resident #004's fall and resulting fracture.

Inspector #577 conducted a record review of resident #004's progress notes, which indicated that the resident had an unwitnessed fall, had complained of pain, and were transferred to an acute care facility for an assessment.

On August 25, 2017, the Inspector reviewed the home's policy titled "Falls Prevention - #CL 1-29" last revised December 1, 2016, which indicated that a falls risk assessment and a post falls risk assessment were to be completed after a fall. A review of the home's "Falls Prevention and Management Toolkit" last revised April 2017, indicated that registered staff were to complete a post fall screen for environmental factors after a fall.

Inspector #577 conducted a record review of resident #004's health care records and could not find a post-fall screening assessment completed after the resident's fall.

During an interview with RN #137 on August 25, 2017, they reported that a post fall screen for environmental factors was not completed for the fall.

During an interview with RAI Coord #131, they confirmed that resident #004 did not

receive a falls assessment, a falls risk assessment or a post fall screen for environmental factors after their fall.

During an interview with the DOC on August 25, 2017, they confirmed that a post fall screen assessment had not been completed after resident #004's fall. [s. 49. (2)]

The decision to issue a Compliance Order was based on the home's ongoing non-compliance with this section of the legislation, the severity was of actual harm to residents that had fallen, the scope of a pattern, was determined. The home had a history of non-compliance in this area of the legislation as follows:

- a WN during the Resident Quality Inspection #2017_624196_0005 issued on March 21, 2017,
- a CO during the Follow Up Inspection #2017_616542_0002 issued on March 7, 2017, and complied on April 18, 2017,
- a CO during the Follow Up Inspection #2016_391603_0024 issued on November 25, 2016, and complied on February 27, 2017,
- a VPC during the Resident Quality Inspection #2016_435621_0012 issued on July 7, 2016, and
- a CO during the Complaint Inspection #2016_333577_0011 issued on July 6, 2016, and complied on November 7, 2016. (617)

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

Feb 28, 2018(A3)

Ontario

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 58. Every licensee of a long-term care home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion. O. Reg. 79/10, s. 58.

Order / Ordre :

The licensee shall:

1) Develop and implement a system to ensure all staff providing care to residents are aware of any assessments by the physiotherapists that change the residents' transfer needs, and that this information is incorporated into the plan of care for the resident with clear directions for staff, and

2) Develop and implement an auditing process to ensure staff are aware of resident transfer requirements and follow the required steps to deliver the required care.

Grounds / Motifs :

1. 1. The licensee failed to ensure that when transferring resident #008, staff used devices and techniques that maintained or improved, wherever possible, the resident's weight bearing capability, endurance and range of motion.

The home submitted a CI report related to an incident that caused an injury to resident #008 for which the resident was taken to hospital which resulted in a significant change in the resident's health status. The CI report indicated that resident #008 complained of pain after an activity. Resident #008 was complaining of pain, and was treated with analgesia. The resident's family member took them to the hospital where they were diagnosed and treated for an injury.

On August 28, 2017, in an interview with resident #008 they explained to Inspector #617 how they had fallen while being assisted by a PSW, and were injured as a result. Resident #008 further explained that at the time of the fall, they were required to use a a specific device for transferring. Resident #008 reported that they couldn't remember the date of the fall.

A review of resident #008's progress notes, post fall assessments and safety incident report indicated that two weeks prior to the CI report submitted to the Director, the resident fell while being assisted with an inappropriate transfer. At the time of the fall resident #008's transfer status had been changed to use a specific device for transferring and the PSW did not use this device for the transfer.

The CI report and the interview with resident #008 identified that staff did not use the appropriate device to transfer the resident on two separate occasions.

On August 29, 2017, in an interview with PSW #141 they confirmed to the Inspector that at the time of the incident they transferred resident #008 by using an incorrect technique which resulted in the resident falling to the floor. PSW #141 further confirmed to the Inspector that they did not use a specific device during the transfer. PSW #141 explained that at the time of the transfer they were not aware that the resident's care plan had changed.

A review of resident #008's health care record indicated that on a particular date PT #117, assessed the resident's transfer status and determined that the resident was to be transferred using a specific device.

On August 29, 2017, in an interview with PT #117, they confirmed to the Inspector that they assessed the resident and determined that the resident needed to use a specific device for all transfers. PT #117 explained to the Inspector that at the time of the assessment they informed the registered staff that they needed to update the resident's care plan interventions to instruct the staff to use the specific device with all transfers and change the transfer logo at the resident's beside.

On August 29, 2017, in an interview with RPN #142, they confirmed to the Inspector that they had changed resident #008's care plan and logo at their bedside to indicate that for all transfers they were to use the specific device. RPN #142 reported to the Inspector that they attended to resident #008's fall in which PSW #141 incorrectly provided the resident with a transfer.

In an interview with RN #143, they confirmed that they had assessed resident #008's pain when the critical incident occurred. RN #143 confirmed to the Inspector that at the time of the incident, the resident was required to use a specific device for transferring and that the staff did not use the device when they assisted the resident

to transfer. RN #143 clarified that all transfers according to the PT assessment required the use of the specific device.

In an interview with CM #138, they confirmed to the Inspector that when the PT assessment indicated the use of a specific device for transfers, they expected the staff to transfer resident #008 using the specific device on both occasions when they fell. [s. 58.]

The decision to issue a Compliance Order was based on the home's ongoing non-compliance unrelated to this section of the legislation, the severity was of actual harm to a resident who was not transferred in accordance with the Physiotherapist's directions and resident's care plan, the scope was isolated, was determined. (617)

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

Feb 28, 2018(A3)

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The Licensee shall ensure that:

All staff including all leadership positions receive all of the mandatory training in accordance with the LTCHA and Regulation prior to assuming their responsibilities.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that all staff have received training in the home's policy to promoted Zero Tolerance of Abuse and Neglect of residents before performing their responsibilities.

On September 6, 2017, in an interview with the DOC they informed the Inspector that VP #163, had been hired on a specific date, as the VP of Senior Health Services and then on a later date assumed the acting Administrator role for the home.

A review of VP #163's "Education Master" file dated two months after their initial hire date, did not indicate that they were trained in the home's policy for Zero Tolerance of Abuse.

In an email dated September 6, 2017, from the DOC to the Inspector, the DOC clarified that VP #163 had not been trained in the home's Zero Tolerance of Abuse Policy and was scheduled for their training.

During the time when VP #163 was acting Administrator till the date they were scheduled for their training, they had not been trained in the home's policy for Zero Tolerance of Abuse.

The decision to issue a Compliance Order was based on the home's ongoing noncompliance with this section of the legislation, the severity of actual harm to residents that were abused, the scope was isolated, was determined. The home had a history of noncompliance in this area of the legislation as follows:

-a VPC during Inspection #2016_246196_002 issued on January 21, 2016, and
-a WN during Inspeciton #2016_391603_002 issued on October 11, 2016. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Dec 31, 2017(A2)

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

Ministère 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

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27 day of December 2017 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RYAN GOODMURPHY - (A3)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Sudbury